

AN EVALUATION OF THE ROLE OF
SOCIAL COMPETENCE IN SELF-IMAGE DISPARITY

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CHAPTER I

INTRODUCTION

The phenomenal self--the self as seen and experienced by the individual himself--has been the focus of increasing theoretical and empirical interest during the past two decades (Wylie, 1961; McCandless, 1967). As chronicled by Wylie, there was a strong emphasis on the self early in the history of American psychology, with William James and the Introspectionists according the concept an important place in their thinking. From the second through the fourth decades of the twentieth century, however, constructs of the self received little attention from the dominant Behaviorist school of psychology. Freud's early focus on the Id as the primary determinant of intrapsychic behavior further limited emphasis on the Ego or self as an important concept.

Freud's later works on the Ego, ideas of the neo-Freudians and Ego psychologists, Gestaltists, Phenomenologists and eclectic clinically oriented workers have re-emphasized the relevance of concepts of the self for understanding human behavior. Wylie (1961) provides a comprehensive overview of important theoretical and empirical approaches to "self psychology" as well as an excellent critique of the problems of research in the area, and McCandless (1967) illustrates recent findings and approaches to the self-concept.

After an initial emphasis on a unidimensional self-concept (Rogers, 1951; Snygg & Combs, 1949), there has been a rapidly increasing interest in self-ideal discrepancy--the difference between the way an individual sees himself and the way he would ideally like to be. Rogers and his colleagues (Rogers & Dymond, 1954) were among the earliest investigators to focus on self-ideal discrepancy. They viewed self-image disparity as negatively and linearly related to adjustment. Later investigators (Altrocchi et al., 1960; Byrne, 1961; Hillson & Worchel, 1957; Feder, 1967; 1968) challenged and modified the Rogerian view, finding that only individuals with certain types of maladjustment or certain psychological defenses exhibited self-image disparity.

Zigler and his colleagues have provided the most interesting work to date. These investigators have shown that a developmental approach to human behavior, which they measure by a Social Competence scale, can account for many facets of behavior--normal and pathological--including self-image disparity.

The present study grows out of the developmental approach to self-image disparity advanced by Achenbach and Zigler (1963). One of the tenets of this position is that all human behavior can be integrated and understood from a developmental point of view. The present study will retest the Achenbach and Zigler hypotheses concerning the relationship between social competence and self-image disparity, and it will also evaluate the "maladjustment" and "defensiveness" interpretations of self-image disparity within the developmental framework.

A formal statement of hypotheses for the present investigation is presented at the end of Chapter I.

In this chapter, a review of the major interpretations of self-image disparity is presented, followed by a proposed integration of the major views within a developmental framework. A discussion of the recent findings most relevant to the present investigation then leads to a statement of the problems to be investigated and a listing of hypotheses.

Rogersian Position: Self-Image Disparity as Indicative of Maladjustment

During his more than 20 years of clinical practice, Carl Rogers developed his client-centered approach to the treatment of psychopathology. The major tenet of this position is that the maladjusted or neurotic individual, compared to the normal or adjusted, has a low self concept and frequently has unrealistically high goals for himself. In its most basic form, the Rogersian position is a theory about self-ideal discrepancy.

In general, then, the individual sees himself as entering therapy in distress, decidedly maladjusted, very unlike the person he wants to be. During therapy he moves significantly in the direction of adjustment...becomes inwardly more comfortable and less tense, sees others as more like himself, and relates more comfortably to them....He alters his personal goal in a realistic and more comfortable direction. (Rogers & Dymond, 1954, p. 418)

An extensive research program was designed to evaluate the efficacy of client-centered therapy and was based on the discrepancies between clients' real and ideal selves. The major instrument of research consisted of 100 descriptive

statements, such as "I am a submissive person," "I am likable," "I am really disturbed," which were provided for a 9-point, forced normal distribution Q-Sort for both real and ideal selves. Rogers and Dymond (1954) note that the forced normal distribution was expected to lead to "finer differentiations than uncontrolled sorting" (p. 57).

The series of experiments reported by Rogers and Dymond provided for good control groups and adequate scoring procedures. In general, the results of the studies provided support for Roger's ideas on self-ideal discrepancy. Clients who entered therapy with high discrepancies between self and ideal, and who stayed in therapy for some time, showed a decrease in self-ideal discrepancy at the end of successful therapy and at later follow-up periods.

Of importance to later work and to the present study, there are several aspects of these findings which should be noted. First, Rogers and his colleagues worked primarily with college students and within academic communities. It can be argued that the selectivity of this population might limit the generalizability of the findings.

Next, Rogers and his colleagues themselves noted that a lack of self-ideal discrepancy in their results might be shown by two entirely different types of individuals: one having "a reasonable degree of adjustment, inner comfort and maturity...(or)...a highly defensive paranoid individual" (Rogers & Dymond, 1954, p. 430). This aspect of defensive behavior was the basis for another interpretation of self-image disparity, which is presented later in this chapter.

Rogers and his colleagues state:

A negatively described aspect of the individual's private world--a deprecativ self-sort, a high discrepancy between self and ideal...has...only one sort of meaning. It indicates stress, tension, maladjustment, etc. within the individual.... (Rogers and Dymond, 1954, p. 430)

This statement is noted because it is disparate with the developmental point of view to be presented below. In this same context, it should be noted that while Rogers and his colleagues found a decrease in self-image disparity with increasing "adjustment" after psychotherapy, they note that this change to self-acceptance is "not great or perfect." Some implications of this finding will be discussed later in this chapter.

In summary, the major tenet of the Rogerian view of self-ideal discrepancy is that it is an indication of maladjustment. It should be noted that there have been contradictory findings on this issue. Many studies have shown the predicted relationship between self-acceptance and adjustment (Rogers & Dymond, 1954; Calvin & Holtzman, 1953; Bills, 1954; Chase, 1957; Cowen et al., 1957; Hanlon et al., 1954; Martire & Hornberger, 1957; Shlien et al., 1962; Turner & Vanderlippe, 1958; Williams, 1962), while other studies have found either no relationship or a negative relationship between self-acceptance and adjustment (Borislow, 1962; Kamano, 1961; Zuckerman & Monashkin, 1957; Achenbach & Zigler, 1963; Katz & Zigler, 1967; Feder, 1968). And still others found a curvilinear relationship between self-acceptance and adjustment

(Block & Thomas, 1955; Chodorkoff, 1954; Friedman, 1955; Hillson & Worohel, 1957).

While Rogers and his colleagues generally supported their views about self-image disparity and adjustment, they noted several findings which could not be explained by their position. These disparate findings have proven to be consistent with later interpretations of self-image disparity. A discussion of these later interpretations follows.

Defensiveness Position: Self-Image Disparity as Indicative of Certain Psychological Defenses

This orientation toward the meaning of self-ideal discrepancy limits and qualifies the Rogerian view. Both this and the Rogerian position agree that a large self-image discrepancy reflects pathology in the individual. But the advocates of the defensiveness interpretation of self-image disparity suggest that only a particular type of maladjusted individual rates himself grossly negative relative to his ideal.

Altrocchi et al. (1960) related self-ideal discrepancy to the repression-sensitization dimension of defensiveness. The repression-sensitization dimension is a bipolar categorization of defensive behaviors. Both repression and sensitization refer to attempts to reduce anxiety and to cope with psychologically threatening situations. Responses indicating repression

...are those responses which involve avoidance of the anxiety-arousing stimulus and its consequents. Included here are repression, denial, and many types of rationalization. [Sensitization includes]...behaviors

which involve an attempt to reduce anxiety by approaching or controlling the stimulus and its consequents. [These] mechanisms include intellectualization, obsessive-compulsive behaviors, and ruminative worrying. (Byrne, 1964, p. 169)

Altrocchi et al. (1960) and Byrne (1961) both found that sensitizers had significantly larger self-ideal discrepancy scores than repressors. Feder (1968) had similar findings, and suggested that self-ideal discrepancy may be related to a defensive style continuum as well as to, or instead of, an adjustment-maladjustment continuum. The Feder study, which also attempted to include the social competence variable, will be discussed at length later in this chapter.

A related approach to self-ideal discrepancy was shown by Hillson & Worchel (1957), who used the Self Activity Inventory as an instrument for obtaining real- and ideal-self ratings. The SAI is composed of 54 statements describing responses to the arousal of hostility, achievement, sexual and dependency needs. Almost all of the available responses are considered ineffectual as they are likely to precipitate conflict with social requirements or not to reduce the conflicts involved. Subjects rate themselves on a five-point scale ranging from "never" to "always" how much the activity described is like them. On other presentations, the subjects rate the items according to how much they would like the item to be like themselves (ideal), and how much the item is like a generalized other. Some samples of items on the SAI are: "Feels he must win an argument," "Plays up to others in order

to advance his position," "Tries hard to impress people with his ability."

Presenting this instrument to groups of normal, neurotic and schizophrenic subjects, Hillson and Worchel found: 1) that neurotic subjects gave poorer self-appraisals than either normal or schizophrenic subjects; 2) that neurotic and normal groups did not differ on ideal ratings, while the schizophrenic sample had significantly lower ideal ratings than the other two groups. After statistically partialing-out the self rating, they found that the self-ideal discrepancy for the neurotic group was greater than for the normal and schizophrenic groups. They found no difference between the normal and schizophrenic groups on self-ideal discrepancy after the statistical adjustment.

These investigators thus confirmed their predictions that: a) maladjusted individuals characterized by anxiety would present a depreciative self picture, report high ideals, and show a high discrepancy between self and ideal concepts; b) maladjusted subjects with defensive patterns (denial) would show little discrepancy between self and ideal, and would present a picture similar to that of normals.

It should be noted that these Hillson and Worchel findings parallel the findings of Rogers and his colleagues, who did not predict the "defensiveness" finding. Proponents of the development approach to behavior, including self-image disparity, have incorporated the above findings into their point of view. The interrelationships between the different major interpretations of self-ideal discrepancy will be

discussed after the following summary of the developmental point of view.

Developmental Position: Self-Image Disparity as Indicative of Social Competence Level

Zigler and his colleagues view behavior, normal or pathological, overt or intrapsychic, as influenced by an individual's level of maturity. A Social Competence scale has been used to assess the developmental level of adults.

The term social competence describes an individual's level of achievement in intellectual, social and interpersonal functioning, as measured by certain biographical variables. These variables are intelligence, education, occupation, employment history and marital status. The theoretical basis for selecting these variables to measure social competence has recently been elaborated by Phillips (1968). Social competence is a construct used to describe an individual's level of effective social adaptation. This effectiveness in social adaption

...is expressed in the degree of competence attained in two areas of function. These are (1) the impersonal world of technological and socioeconomic activities, in which the person acquired an education, develops work skills, and insures the well being of himself and his dependents, and (2) the world of personal relationships, of intimate contact with others, which require an abundance of sensitivity and awareness of human motives and an intuitive grasp of the subtleties of human relationships. (Phillips, 1968, p. 3)

Thus, indices of an individual's performance in community living constitute a measure of his social competence. Phillips further explains that social competence reflects

more than psychological development. "It also expresses the individual's potential for meeting those expectancies for adaptive behavior that are imposed by virtue of living in society" (Phillips, 1968, p. 59). In other words, an individual's past level of functioning in complex social situations is viewed as an indication of his potential for future social adaptation. According to this theory, if one knows the minimal societal expectations for an individual, and knows his social competence--his adaptive potential--one should be able to predict patterns of the individual's behavior.

The above view of social competence was utilized by Phillips and Zigler, who employed the concepts of developmental theorists, especially Piaget and Werner, to advance a developmental approach to the problems of psychopathology. The general thesis of this position is that there is a continuum of growth underlying psychological processes. This growth is characterized by increasing differentiation, hierarchization and independence of psychological functioning. As mentioned earlier, attained levels of maturity or development are viewed as being reflected in both intellectual and social functioning, and as underlying both normal and pathological behavior.

In support of their developmental view, Phillips and Zigler conducted several investigations in which the biographical variables of age, intelligence, education, occupation, employment history and marital status were used as indices of personal maturity or social competence. The findings indicated that psychiatric patients who were high as

compared to low on the scale of social competence were more likely to be diagnosed as manic-depressive or psychoneurotic than schizophrenic or having a character disorder (Zigler & Phillips, 1961a), were more likely to exhibit thought than action symptoms (Phillips & Zigler, 1961), and had a better prognosis (Zigler & Phillips, 1961b).

Of significance to the present study was the finding that symptoms of high competence subjects were of the "self deprivation and turning against the self" orientation, while symptoms of low competence patients were oriented to either "self-indulgence and turning against others" or "avoidance of others" (Zigler & Phillips, 1960). This finding is consistent with the developmentally derived proposal that symptoms showing self-deprivation and turning against the self indicate an introjection of social standards congruent with a high level of social maturity (Phillips & Rabinovitch, 1958).

Achenbach and Zigler (1963) postulated that

If it is true that psychological development as reflected in social competence constitutes a general dimension of behavior which cuts across the usual distinctions of "normality" and "pathology," then a correlate of personality as important as self-image disparity should be at least partially a function of such development. (Achenbach & Zigler, 1963, p. 198)

These investigators predicted that real-ideal discrepancy would be positively related to social competence, reflecting an individual's level of maturity, and that this relationship would hold for both adjusted and maladjusted individuals. The rationale underlying the predicted positive relationship between self-image disparity and social

competence was based on two factors. The first factor, which they termed guilt, was based on the idea that individuals at a high level of maturity would have a greater capacity for introjecting societal demands, mores and values than lower developmental individuals. Zigler and Phillips (1960) found that persons who could be classified as high social competence showed a high degree of introjection of societal standards. It was thus anticipated that high competence subjects would make more and greater self demands, and would be more critical of their own progress toward their goals than lower competence subjects. The second factor was based on the developmental finding that a greater degree of cognitive differentiation exists at higher levels of development (Piaget, 1951; Werner, 1948). More highly developed individuals were thus expected to utilize more cognitive categories and to make finer distinctions than less mature individuals. Achenbach and Zigler then predicted that the greater differentiating ability of the more mature individual would be manifest in a greater self-image disparity than that of a less mature individual when rating first real and then ideal selves on an instrument providing several alternative responses.

Achenbach and Zigler tested their view that self-ideal discrepancy was a function of both guilt and cognitive differentiation by employing measures designed to differentially tap these two factors. Subjects were 20 psychiatric and 20 nonpsychiatric hospital patients, subdivided into equal numbers of high and low social competence. Each subject completed a questionnaire, composed of self-referent statements

and providing for six alternative responses, three times: once for real self, once for ideal self, and once for social self (the way the individual thinks others see him). Real, ideal and social self responses were then obtained on a trait list which required simple "yes" or "no" responses.

The disparity between real self and social self was assumed to be less subject to influence by guilt, and did result in a smaller disparity than real-ideal responses. The assessment of disparity by the trait list, which allowed only "yes" or "no" responses and was thus less sensitive to differences in cognitive differentiation, resulted in smaller discrepancy scores than found with the questionnaire, which provided six alternative responses to each item. Supporting their developmental thesis, then, Achenbach and Zigler found differences between high and low social competence groups in self-image disparity to be greatest on instruments involving both guilt and cognitive differentiation factors, smaller on instruments involving a single factor, and non-existent on a measure in which both factors were minimized.

Some aspects of the above study might limit the interpretation of the findings. First, subjects were adults whose developmental status was assessed on the basis of the social competence scale. While previous studies have shown the utility of the social competence scale for differentiating adult subjects along a developmental dimension (Zigler & Phillips, 1961a; 1961b; Phillips & Zigler, 1961; Zigler & Phillips, 1960), the developmental position would be more credible if it were tested for a group of subjects classified on an indisputable measure of maturity.

Following the accepted procedure in self-image disparity research, Achenbach and Zigler did not indicate whether differences between groups in discrepancy scores was due to differences in self ratings or in ideal ratings. Some have argued that any important differences in discrepancy scores will be due to differences in self ratings (McCandless, 1967; Byrne, 1964; Wylie, 1961), since they expect ideal ratings to be consistent among all groups. Certainly a better understanding of the dynamics of self-image disparity might be gained from an assessment of both the real and ideal components of the self-image disparity measure.

Another methodological problem, found in most self-image disparity research, is also shown in the Achenbach and Zigler study. In scoring self-ideal discrepancy, they counted only the number of changes between a subjects' ratings, ignoring direction and magnitude of change. It has been suggested that "...the practice of absolute summation (of discrepancy scores) seems questionable..." (Wylie, 1961, p. 75).

Meeting the objections to the Achenbach and Zigler study, Katz and Zigler (1967) designed another test of the developmental level hypotheses. They reasoned that if self-image disparity is a developmental phenomenon, then there should be an ontogenic sequence in the phenomenon, with younger children exhibiting less disparity than older children. They further argued that mental age (which has been considered a better index of developmental level than chronological age) should reflect differences in developmental level within a given chronological age group. Thus they predicted a

positive relationship between self-image disparity and age and between self-image disparity and I.Q. (mental age/chronological age) within a group of children at the same chronological age.

Testing 120 children from fifth, eighth and eleventh grades on the measurements used by Achenbach and Zigler but modified for children, Katz and Zigler supported their predictions. As chronological age and/or I.Q. increased, so did self-image discrepancy scores. Both magnitude and direction of change were included in the Katz and Zigler analyses. The larger disparity in older and brighter children was accounted for by both decreased self-evaluations and increased self-ideal images.

The results of the Katz and Zigler study, representing a further test of the developmental hypothesis, provided further support for the position advanced by Achenbach and Zigler and provided empirical support for the general developmental approach advocated by Zigler and his colleagues. Other unpublished studies involving children of different ages and children of differing I.Q.s found additional support for the thesis that self-ideal discrepancy is a developmental phenomenon (Zigler, 1969).

Thusfar, the three major interpretations of self-image disparity have been reviewed. It was noted above that proponents of the developmental position have suggested that previous findings could be incorporated into the broader developmental perspective. The following section of this chapter will review the "maladjustment" and "defensiveness"

interpretations from the developmental point of view and suggest a logical integration of the three positions.

The Developmental Position as Incorporating
Previous Findings on Self-Image Disparity

Self-Image Disparity, Maladjustment, and Social Competence

Rogers and his colleagues found that a high discrepancy between real and ideal self reflected only one thing: maladjustment. It may be important that these investigators equated stress, tension and maladjustment. It is obviously important that the client-centered psychotherapy which was the basis of their research defined maladjustment as essentially a discrepancy between an individual's real and ideal self. Thus these investigators focused on the variable of self-ideal discrepancy as an index of maladjustment. And their research results generally supported their views.

According to the developmental view proposed by Zigler and his colleagues, self-image disparity is primarily an indication of an individual's overall development rather than his degree of pathology. While these developmentalists recognize that individuals at all levels of maturity may be or become maladjusted and exhibit maladaptive behavior, they hold that the adjustment-maladjustment continuum is a less important determinant of self-ideal discrepancy than an individual's level of social competence.

On the surface, then, it would appear that the Rogerian and the developmental positions on self-image disparity are opposed. However, a closer comparison of the two views invite several points of reconciliation. First, Rogers' college

student and academic community subjects would most probably be rated as high competence on the developmental scale. Certainly on the variables of intelligence, education and occupation they would be above average, so that Rogers and his colleagues were probably working with high competence individuals with varying degrees of self-image disparity. Within a given maturity group there might be differences in self-image discrepancy between adjusted and maladjusted individuals according to the Rogerian theory. The fact that Achenbach and Zigler did not find significant differences between adjusted and maladjusted groups, while finding differences between high and low competence groups on self-image disparity, might reflect the relative importance of social competence as a determinant, or the variability between adjustment and maladjustment within both experimental groups, or both. The fact that Rogers and his colleagues noted that their clients' decrease in self-image discrepancy was not great or perfect after successful therapy might support the idea that a) these investigators were working with a selectively high competence population, and b) that high social competence individuals tend to manifest self-ideal discrepancies.

It has been noted that Rogers and his colleagues equated tension and stress with maladjustment. There have been many who felt that there is an optimum level of tension or stress for an individual's development, and that lack of these factors will retard or stop a person's development. Freud's writings concerning the transfer of psychic energy from the Id to the Ego are the earliest statements on the importance

of tension and optimum frustration for the emergence of the social being. Certainly the developmentalists' expectations and findings that self-ideal discrepancy is higher for more highly developed individuals reflects the assumption that these individuals function under a certain amount of tension (the factor named guilt by Achenbach and Zigler). It is possible, then, that Rogers and his colleagues, working primarily with high developmental individuals in a college community, would note the high degree of discrepancy between these individuals' real and ideal selves and relate this to the problems of clients whom they treated, ignoring the developmental implications.

From the above perspective, it appears that the Rogerian findings are consistent with the broader developmental view. The findings from the client-centered therapy of high competence, neurotic individuals can be integrated with the view proposed by the developmentalists that self-image disparity is primarily a reflection of an individual's social competence or maturity.

Self-Image Disparity, Defensive Style and Social Competence

Investigations of self-image disparity by proponents of a defensive style interpretation and a social competence interpretation have agreed on one point: their findings indicate that self-image disparity is not a simple function of maladjustment. Researchers into the repression-sensitization dimension of defensiveness (Altrocchi et al., 1960; Byrne, 1964; Feder, 1967) maintain that individuals utilizing the

defense of sensitization manifest self-ideal discrepancy while repressors do not. The developmental theorists argue that: a) self-image disparity is a function of developmental level, and b) defensive mode is also a function of developmental level. Thus, Achenbach and Zigler interpreted the repression-sensitization findings as consistent with their views. They suggested that sensitizers, who manifest greater self-ideal discrepancies than repressors, are at a higher developmental level than repressors. They cite the defining characteristics of repressors and sensitizers as evidence for such an assumption. Repressors tend to use avoidance, denial and repression as primary modes of defense, while sensitizers respond to and perhaps overinterpret potential threat and conflict, and handle these with the defenses of intellectualization, obsessive-compulsive behaviors or similar defenses. Achenbach and Zigler note that "the symptomatic picture ascribed...to extreme sensitizers...is quite similar to the symptomatic picture found by Zigler and Phillips (1960) in patients who have attained a relatively high social competence level" (p. 205).

At this point it appears that the most important findings on self-image disparity are consistent with a general developmental position. The findings can be combined within a developmental framework that is logically consistent. The combined findings, as interpreted above, would indicate:

1. An individual's social competence level (maturity) will indicate his relative self-image disparity, with high competence persons showing greater self-image disparity.

2. An individual's social competence will influence the type of psychological defenses he employs, with high competence individuals utilizing sensitization defenses and low competence individuals employing repression defenses.
3. An individual within a given developmental level may manifest increased self-image disparity as a result of "maladjustment," as defined by Rogers and his colleagues.

It would thus seem that self-image disparity may be viewed as largely a developmental phenomenon. However, a recent study has questioned this thesis. A review of the recent findings will lead to a statement of the problem for the present investigation.

Contradictory Findings: Adjustment, Defensiveness and Social Competence

The most recent findings seem to contradict the developmental thesis concerning self-image disparity. Feder (1968) investigated the relationships of three variables--adjustment-maladjustment, repression-sensitization and social competence--to self-image discrepancy. She found that neither adjustment nor social competence was related to the dependent variable, while defensive style (repression-sensitization) was related to self-image disparity. Eighty hospitalized male patients, 40 psychiatric and 40 medical or surgical patients, constituted Feder's maladjusted (psychiatric) and adjusted (medical/surgical) groups. These groups were further subdivided by high and low social competence and by repression-sensitization

scores. Social competence was determined from the same variables employed by Achenbach and Zigler (1963). Repression-sensitization was measured by the Repression-Sensitization scale described by Byrne from M.M.P.I. items. Self-ideal discrepancy was determined by a Q-Sort, administered once for perceived self and once for ideal self. Simple summation of the changes between the two sorts was the method used to obtain discrepancy scores.

Consistent with the Achenbach and Zigler findings, Feder found no significant relationship between self-image disparity and adjustment-maladjustment. Unlike the Achenbach and Zigler findings, however, no relationship between social competence and self-ideal discrepancy was found. The only significant finding in the study was between self-image disparity and repression-sensitization, with repressors showing smaller discrepancy scores than sensitizers.

These most recent findings by Feder call into question the developmental position supported in the earlier work. It was the purpose of the present study to investigate the disagreement between the two sets of data and to attempt to resolve some of the issues surrounding the meaning of self-image disparity.

There are several possible explanations for the divergent empirical findings concerning self-image disparity:

Task Variables

Social Desirability Response Set

Procedural Variables

Other Related Variables

These possible explanations are discussed below.

Task Variables

The most frequent comment found in critiques of self-image research concerns the wide variety of instruments used to measure the construct (cf. Wylie, 1961; McCandless, 1968). The criticism is that the variety of instruments are probably measuring different things, or different aspects of the same phenomenon. Feder suggests that the discrepancy between her study and earlier work may be due to task variables. She notes: "A main difficulty in comparing these results with those obtained in other studies is the fact that different self-acceptance instruments have been used and may not be comparable" (Feder, 1968, p. 321).

Examination of the instrument used by Feder (Appendix D) leads to a possible task variable interpretation of the divergent findings. It is likely that some low competence subjects (i.e., subjects with relatively low intelligence, little education, low-grade occupations) would not comprehend such words as "ardent," "candid," "intuitive," "spontaneous." Even high competence subjects might have difficulty rating themselves on such items. In addition, the forced rectilinear distribution of responses on Feder's instrument would minimize the effects of cognitive differentiation since it attempts to force all subjects to utilize the same differentiations on the task. This might be expected to limit the potential differences between groups of subjects.

Feder seems to suggest that the discrepant findings

are due to uncontrolled social desirability factors in the other studies. She calls attention to the fact that the Q-Sort used in her investigation was "minimized for social desirability...(and) may be getting at quite a different aspect of a self-acceptance dimension than other instruments....(as) the results of this study were less confounded by the social desirability variable" (Feder, 1968, p. 321).

Social Desirability Response Set

Feder's interpretation, noted above, is consistent with others' views. Crowne and Stephens (1961) feel that two-thirds of the relevant findings in self-concept research are due to the social desirability factor. The bases for this assumption are that no two people will view a test in quite the same way, and that individuals exercise "impression management" in test taking behaviors.

There has been a good deal of research on impression management techniques of hospitalized patients (cf. Braginsky et al., 1969) and on social desirability response set (cf. Crowne & Marlowe, 1964). Crowne and Marlowe have concluded that individuals scoring high on their Social Desirability scale manifest a high need for approval. It seems reasonable to conclude that a need for approval might play some part in subject's responses to paper and pencil tests. The exact nature of the relationship between social desirability and social competence is thusfar unclear. Feder did obtain scores on the Social Desirability scale for her subjects, but she did not report those scores nor their relationship to social competence.

On the basis of descriptions of high and low competence individuals, it might be expected that a social desirability response set might be concomitant with low social competence. If low social competence individuals (who have been shown to indicate satisfaction with their present achievements) are also repressors (who tend to use denial and repression in response to threatening situations), then it would be expected that these individuals would attempt to present themselves in a "socially desirable" manner. At this point, however, the relationships between social competence, social desirability and sensitization-repression remain empirical questions.

Procedural Variables

Possibly related to the divergent findings of Achenbach and Zigler and Feder are certain procedural points. First, Feder classified subjects as high or low social competence on the basis of an information sheet completed by the subjects. If the above suggested relationships between social competence and social desirability are correct, it seems likely that low competence subjects might falsify information regarding education, occupation and employment history for an unknown researcher. If such falsification did occur, it would have resulted in erroneous placement of these subjects into competence groups.

Another potentially important procedural point in Feder's study is questionable. It appears that differential information was given to psychiatric and nonpsychiatric patients. Although the patient information procedure is not reported

in the study concerning social competence (Feder, 1968), in another aspect of the same study it is reported:

All medical patients who met the initial criteria for inclusion were individually asked if they would volunteer to participate in a study being conducted by the psychology department. Psychiatric patients who met the initial criteria were told that the testing was just a part of the routine psychological tests which are given an appointment to be tested. (Feder, 1967, p. 403)

The two different sets of information might have resulted in differential response sets for the two groups.

The design of Feder's investigation required equal numbers of repressors and sensitizers at each competence level, thus creating a forced independence between social competence and repression-sensitization. If the developmental theorists are correct in their assumption that sensitizers tend to be high competence and repressors low competence individuals, then a correlational analysis would provide a better index of the relationship between the variables of social competence and repression-sensitization.

Other Related Issues

Descriptions of individuals manifesting repression defenses appear to be quite similar to descriptions of individuals who show a "turning against others" or "turning away from others" role orientation, as described by Phillips (1968), while descriptions of sensitizers are similar to descriptions of individuals manifesting "turning against the self" role orientations.

Repressors manifest

...those responses which involve avoidance of the anxiety arousing stimulus and its consequents. Included here are repression, denial, and many types of rationalization. At the sensitizing extreme of the continuum are behaviors which involve an attempt to reduce anxiety by approaching or controlling the stimulus and its consequents. The latter mechanisms include intellectualization, obsessive-compulsive behaviors, and ruminative worrying. (Byrne, 1964, p. 196)

Zigler and his colleagues have found that low developmental psychiatric patients typically manifest symptoms of an "avoidance of others" or "turning against others" orientation, while high developmental patients manifest a "turning against the self" orientation. Phillips (1968) provides descriptions of these orientations:

...a symptomatology of Turning Against the Self reflect(s) feelings of depression, hopelessness, pessimism, despair, loneliness, apathy, or disinterest; of tension, worry or anxiety; or of an insecure self-criticalness. [high developmental]

Patients with the Role Orientation of Turning Against Others convey the qualities of suspiciousness, hostility, and deficiency in conscience;....The Role of Avoidance of Others [implies] a sense of emotional isolation; of self-effacement or a pollyannaish denial of anger and hostility... [low developmental]. (p. 140-141)

The similarity of descriptions for repressors-sensitizers and low competence-high competence individuals raises a question as to whether both the Repression-Sensitization scale and the Role Orientation scale are measuring the same aspect of defensiveness.

In both the Achenbach and Zigler (1963) and Feder (1968) studies, psychiatric patients represented a

maladjusted group and medical and surgical patients represented an adjusted group. Differences in self-image disparity were found between high and low competence subjects and between repressors and sensitizers. It might be argued that both high competence subjects and sensitizers reflected "neuroticism" when manifesting high self-image disparity. Only an independent test of the neuroticism factor can answer this question.

The preceding has indicated the background for the present study, and the general outlines of the problems investigated in this study have been presented. A more concise statement of the problem follows, and leads to a statement of hypotheses.

Problem

The primary focus of the present study was on the relationship between social competence and self-image disparity. Two previous investigations produced conflicting results. Achenbach and Zigler (1963) found significant differences between high and low competence subjects, with high competence subjects showing a greater self-image disparity. Feder (1968) found no differences between high and low competence groups on a different test of self-image disparity. The present study proposed to test the relationship between social competence and self-image disparity on the Trait List and Questionnaire measures used by Achenbach and Zigler and on the Q-Sort measure used by Feder. It appeared that having the same subjects complete all three measures might be the best way to

test the task variable interpretation of the discrepant results. Another possible task variable interpretation of the conflicting findings was proposed: that subjects might not have been able to respond knowledgeably to the items in Feder's Q-Sort. A simple multiple-choice vocabulary test, containing items from the Q-Sort and from the other two self-image measures, was devised to test this possible interpretation.

There were also some procedural criticisms of previous investigations. Attempting to meet the criticisms of earlier work, the present study provided the same information to all subjects, obtained a "double check" on accuracy of the biographical information provided by subjects when possible, and scored self-image disparity for both magnitude and direction of change when appropriate.

Another area investigated in the present study was the relationship between repression-sensitization and self-image disparity. Although Feder found no relationship between social competence and self-image disparity, she did report that sensitizers show significantly more disparity than repressors on self-ideal ratings. Achenbach and Zigler had argued that repressors were similar to low competence subjects and sensitizers were described in terms similar to descriptions of high competence individuals. It has been noted that Feder's experimental design forced an independence between these two variables. It was decided that a better test of the hypothesis that repression-sensitization is related to social competence would involve a correlational design, in which the sensitization-repression scores of the total experimental population

(differing widely in social competence) were related to social competence ratings.

Yet another aspect of the meaning of self-image disparity involves its correlation with social desirability. It has been proposed that most self-image research is really tapping the social desirability factor, or that some tests of self-image disparity tap this factor. In view of the increasing importance placed on response set variables in psychological research, it seemed imperative to find the relationship between each of the paper-and-pencil test scores used in this study and social desirability response set.

In addition to investigating the interrelations between social competence, social desirability and repression-sensitization as they relate to self-image disparity, the present study explored the relationship between two scales of psychological defenses. Both the Byrne scale of repression-sensitization and the Phillips Role Orientation scale propose to differentiate individuals on the basis of kinds of psychological approaches to life. While descriptions of the dichotomous repressors-sensitizers appear to correspond to descriptions of "turning away from or against others" and "turning against the self," the amount of overlap of the two scales remains an empirical question. Since the Phillips Role Orientation scale was derived from studies of psychiatric patients' symptom orientations, it was possible to evaluate the scale's correspondence with the original purpose. This was done by comparing psychiatric patients' scores on the

scale role orientation with their scores on symptom role orientation, as defined by Phillips and Ziglers' early work.

The final problem approached in the present investigation concerned the relationship between social competence, defensive style and neuroticism as they relate to self-image disparity. The possibility that self-image disparity was due to maladjustment was proposed by Rogers and his colleagues. Later research has been contradictory. Neither Achenbach and Zigler nor Feder found differences in self-image disparity between their adjusted and maladjusted groups that could be attributed to the adjustment-maladjustment factor. Since high social competence individuals and sensitizers manifest high self-image disparity, however, it might be argued that these individuals are actually expressing their neuroticism in their self-ideal discrepancy. In order to provide an independent assessment of neuroticism, and to relate this factor to the other variables in the study, the Maudsley Extra-version-Neuroticism scale was administered to subjects.

Hypotheses

The major hypotheses concern the relationship between social competence and self-image disparity, as the study was designed to investigate these variables. There were also several hypotheses concerning relationships between the other variables.

Social Competence and Self-Image Disparity

1. It was predicted that a significant relationship

would be found between social competence and self-image disparity as measured by the Questionnaire and the Trait List, with high social competence subjects showing more self-image disparity than low competence subjects. This prediction is consistent with the Achenbach and Zigler (1963) findings.

2. Also in keeping with the developmental position, it was predicted that low social competence subjects would make significantly more extreme responses on the Questionnaire than high social competence subjects.

3. In light of Feder's (1968) findings, it was predicted that no significant differences between high and low social competence subjects would be found on self-image disparity as measured by her Q-Sort instrument.

4. It was suggested above that Feder's failure to find a relationship between social competence and self-image disparity may have been due in part to the inability of her subjects to understand many of the words used in her instrument. It was therefore predicted that subjects in the present study would have significantly more difficulty defining the key words employed by Feder than the key words employed by Achenbach and Zigler.

Other Hypotheses

1. It was predicted that social competence would be significantly correlated with repression-sensitization, with high competence subjects utilizing sensitization and low competence subjects utilizing repression. This prediction is consistent with the developmental position

advanced by Zigler and his colleagues, but contrary to the Feder (1968) findings.

2. It was predicted that there would be a significant correlation between social competence and social desirability, with low social competence subjects scoring higher on the Social Desirability scale than high competence subjects. This prediction was based on the similarity of descriptions of low social competence individuals and persons previously found to exhibit the social desirability response set.

3. It was predicted that there would be a significant correlation between social desirability and repression-sensitization, with repressors scoring higher on social desirability than sensitizers. This prediction was based on the similarity of descriptions of repressors and individuals previously found to exhibit the social desirability response set.

4. It was predicted that the Phillips Role Orientation scales would significantly differentiate between the high and low social competence subjects, with high competence subjects showing a "turning against the self" orientation and low competence subjects showing a "turning away from others" or "turning against others" orientation. This prediction was based on the findings of Phillips and Rabinovitch (1958), Zigler and Phillips (1960), and Phillips (1968).

5. It was predicted that the symptom role orientation rating for psychiatric patients' symptoms would significantly differentiate between high and low social competence psychiatric patients, with high social competence subjects

manifesting a "turning against the self" orientation and low social competence subjects having either "turning against others" or "turning away from others" symptom orientations.

6. It was predicted that the symptom Role Orientation measure for psychiatric patients would be positively related to their Role Orientation scale scores.

7. It was predicted that the Role Orientation scales would correlate significantly with the Repression-Sensitization scale, with sensitizers exhibiting a "turning against the self" orientation and repressors showing "turning away from others" or "turning against others" orientations.

8. It was predicted that psychiatric subjects would score higher on the Neuroticism scale than nonpsychiatric subjects, but that there would be no significant differences between low and high social competence subjects on the Neuroticism scale.

CHAPTER II

METHOD

Subjects

Eighty hospitalized male patients, 40 psychiatric patients and 40 medical or surgical patients were employed. These two groups of subjects were subdivided into equal groups of high and low social competence. All psychiatric subjects were first admission patients who had been hospitalized for less than 90 days. These patients had no signs of organicity, were judged not to be actively hallucinating, and had not undergone shock treatments for at least three months prior to testing. Diagnoses of psychiatric subjects are presented in Table 1. Medical and surgical patients participating in the study had no previous history of psychiatric hospitalization, no terminal illness, no illness which was judged to have a major psychiatric component, and no signs of organicity. Diagnoses of medical and surgical patients are presented in Table 2.

The age and length of hospitalization of subjects are presented in Tables 3 and 4. F-tests revealed that there were no significant differences in age or length of hospitalization among the four groups.

Thirty of the psychiatric subjects were patients at the Franklin Delano Roosevelt Veterans Administration

Table 1
Diagnoses of Psychiatric Subjects

Diagnosis	Hi Comp. n	Lo Comp. n
Adult Situational Reaction		1
Anxiety Reaction	1	
Depression, Depressive Reaction, Depressive Neurosis	7	
Drug Addiction		1
Obsessive-Compulsive Personality Disorder	1	
Paranoia, Paranoid State	2	1
Passive Dependent Personality	1	
Psychoneurosis	1	
Schizophrenia, Schizophrenic Reaction	1	2
Schizophrenia - Catatonic Type		1
Schizophrenia, Schizophrenic Reaction - Paranoid Type	3	7
Schizophrenia, Schizophrenic Reaction - Schizo-Affective Type	2	4
Schizophrenia, Schizophrenic Reaction - Undifferentiated Type	1	3

Table 2
Diagnoses of Nonpsychiatric Subjects

Diagnosis	Hi Comp. n	Lo Comp. n
Abdominal Pain	1	1
Acute Sinusitis	1	
Broken Leg		2
Broken Wrist	1	
Cardiac Arythmia		2
Cardiac Cathode	1	
Cerebritis	1	
Colitis	1	
Emphesema	1	
Foot Infection		1
G.I. Disorder	1	
Heart Failure	2	1
Hepatitis	1	2
Hypertension	1	
Kidney Stones		1
Lacerations	1	
Laryngscopy		1
Leg Tumor	1	
Nephritis		1
Observation	4	4
Pulmonary Edema	1	

Table 2 (continued)

Diagnosis	H1 Comp. n	Lo Comp. n
Renal Colic		1
Renal Stone		1
Swolen Lymph Glands	1	
Tymor on Coccyx		1
Ulcers		1

Table 3
Group Average Age, Range, and Standard Deviations

Group	Average Age	Range	Standard Deviation
Psychiatric High Competence	39.75	21-55	10.87
Psychiatric Low Competence	34.65	19-55	12.35
Medical High Competence	40.20	19-58	10.70
Medical Low Competence	38.60	19-58	12.58

Table 4

Group Average Number of Days of Hospitalization,
Range, and Standard Deviations

Group	Average Hospitalization	Range	Standard Deviation
Psychiatric High Competence	17.95	4-50	12.60
Psychiatric Low Competence	19.90	3-80	16.69
Medical High Competence	11.05	4-35	8.31
Medical Low Competence	12.60	3-58	11.62

Hospital in Montrose, New York, five were patients at the Worcester, Massachusetts, State Hospital and five were patients at Hall-Brooke Hospital, a private psychiatric hospital in Westport, Connecticut. Of the medical/surgical sample, 25 were medical patients at the Hospital of St. Raphael in New Haven, Connecticut, and ten were surgical patients at that hospital. Five medical patients from the East Orange, New Jersey, Veterans Administration Hospital completed the sample.

Social Competence

The variables of intelligence, education, occupation, employment history and marital status were used as indices of social competence (Achenbach & Zigler, 1963).

1. Intelligence: On the basis of performance on the Shipley-Hartford intelligence survey, subjects were classified as low, average or superior in intelligence.

2. Education: Subjects were classified into one of three categories: none or some grades including ungraded special classes; finished grade school, some high school or finished high school; some college or more.

3. Occupation: The Dictionary of Occupational Titles (United States Printing Office, 1949) was used to place subjects into the categories of unskilled or semiskilled; skilled and service; or clerical and sales and professional and managerial.

4. Employment History: Subjects were rated according to whether they were usually unemployed; had seasonal or

fluctuating jobs, frequent shifts or part-time employment; or were regularly employed.

5. Marital Status: Categories for this variable were single; separated, divorced or remarried; or single continuous marriage.

For each of the above five variables, placement in the lowest category received a score of 0, placement in the middle category received a score of 1, and placement in the highest category received a score of 2. A subject's social competence rating was the average of his scores on the five variables.

Feder's (1968) Biographical Information form was also completed by each subject. This instrument was used to provide information which was not available in medical patients' charts, and to compare self-reports and chart information for psychiatric subjects. The form is shown in Appendix A.

Measures of Experimental Variables

Self-Image Disparity

Three paper-and-pencil tests of self-image disparity were completed by each subject: the Trait List and the Questionnaire used by Achenbach and Zigler (1963) and the Q-Sort used by Feder (1968).

1. Trait List: This measure consists of a list of 30 personal traits, and requires a "yes" or "no" response to indicate whether a trait is characteristic of the subject. A duplicate list of the 30 traits requires a "yes" or "no" response to indicate whether the trait is characteristic of

the way a subject would ideally like to be. A subject's score is the number of discrepancies between his real and ideal ratings. A copy of the Trait List is shown in Appendix B.

2. Questionnaire: This measure consists of 30 self-referent statements which provide six possible responses, ranging from "this is very true of me" to "this is very untrue of me." A duplicate set of statements provide for answers ranging from "I would like this to be very true of me" to "I would like this to be very untrue of me." A subject's scores on this measure consist of:

- A. The number of items on which the rating is different on real and ideal questionnaires. This is the number of changes, or simple summation of discrepancies.
- B. The sum on scaled (good to bad) scores on each of the real and ideal questionnaires. The directional scale was derived by Balla (1969) from a consensus found among subjects in two previous studies using the questionnaire as to the meaning of "good" or "bad" personal attributes.
- C. The total magnitude of changes between real and ideal questionnaires.
- D. The total number of extreme responses on both questionnaires.
- E. The number of items scored in the same extreme direction on both questionnaires (zero changes, extreme responses).

F. The number of items scored in one extreme direction on the real Questionnaire and in the other extreme direction on the ideal Questionnaire (Maximum extreme changes).

A copy of the Questionnaire is shown in Appendix C.

3. Q-Sort: This measure consists of 44 adjectives arranged in alphabetical order below an 11-point, forced rectilinear distribution, Q-Sort box. Subjects are required to place numbers, corresponding to the adjectives, into each of the 44 spaces provided in the box. There are four spaces provided for each of 11 categories, ranging from "most poorly describes me" to "best describes me." A duplicate set of adjectives requires the same ratings for categories ranging from "most poorly describes my ideal" to "best describes my ideal." A subject's score is the number of ratings (number placements) which differ between the real and ideal sorts. An example of this measure is shown in Appendix D.

Repression-Sensitization

Six M.M.P.I. scales comprise the Repression-Sensitization scale used by Altrocchi *et al.* (1960). Three scales, D, Pt. and W.A.S. (Depression, Psychasthenia and Welsh Anxiety Scale), provide items for tapping sensitization. Three scales, I, K and HY (Lie scale, Correction scale and Hysteria) tap the repression dimension. As modified by Byrne (1964), the scale utilizes 101 nonoverlapping items from the original six scales. Of the 101 items, 61 are keyed true and 40 are keyed false. High scores indicate sensitization and low scores indicate repression.

Social Desirability

The Marlowe-Crowne Social Desirability scale (Crowne and Marlowe, 1964) consists of 33 items drawn from a universe of behaviors which are culturally sanctioned and approved but improbable of occurrence. The behaviors represented in the items have only minimal implications for pathology whether answered in the positive or negative direction. Of the 33 items, 18 are keyed true and 15 are keyed false. A high score on the scale reflects a strong social desirability response set, or as Marlowe and Crowne have suggested, a high need for approval.

Role Orientation

Phillips' (1968) Role Orientation Questionnaire consists of 60 items, many drawn from the M.M.P.I. Of the 60 items, 25 comprise a "turning against the self" role orientation, 19 a "turning against others" orientation, and 16 an "avoidance of others" orientation. The role orientation measure was designed to provide a means of measuring role orientations in nonpathological groups. Items for the Role Orientation scale are shown in Appendix E.

Symptom Role Orientation

For psychiatric patients, the original (Zigler and Phillips, 1960) classification of symptomatic role orientation was scored from patients' charts. Patients' symptoms were listed as they appeared in the clinical records, and were then classified into role orientations as specified by

Zigler and Phillips. The testing of psychiatric patients on this variable was designed to retest the Zigler and Phillips hypotheses, and to provide a comparison between the original (actual symptoms) and derived (role orientation questionnaire) measures of an individual's role orientation. The Symptom Role Orientation list is shown in Appendix F.

Vocabulary Test

This test was designed to evaluate the extent to which subjects understood the items on which they rated themselves in the three self-image disparity measures. The test consists of 88 multiple-choice items. Following the Shipley-Hartford vocabulary test format, key words are presented with four alternatives from which to select the correct synonym or definitive word. The first 44 items are the adjectives in the Q-Scrt. The last 44 items consist of nonoverlapping words in the Trait List and key words in the Questionnaire items. A copy of the vocabulary test is shown in Appendix G.

Neuroticism-Extraversion

Eysenck (1958) isolated two pervasive and relatively independent dimensions of personality: extraversion-intraversion and neuroticism, and designed a short scale to measure these two factors. Each of the traits is measured by 24 questions, scored 2, 1, or 0 for the trait. Questions require "yes," "?" or "no" responses. The test of the two dimensions is the Maudsley Personality Inventory (Eysenck, 1962). The Neuroticism scale was used in the present investigation to evaluate possible differences between high

and low social competence groups on this variable. The Extraversion-Introversion scale was included in the investigation to avoid changing the format of the Maudsley inventory.

Procedure

Subject Selection

To provide a clear test of the developmental position concerning social competence, subjects were selected from the extremes of high and low social competence ratings. Persons with social competence scores at or below 0.8 and at or above 1.2 were included in the study as low and high competence subjects, respectively. Individuals who had social competence ratings in the middle range were excluded from the experimental sample. Every attempt was made to insure that information about the five variables used in rating social competence was reliable. In order to exclude "chronically hospitalized" psychiatric patients, a limit of three months hospitalization was set as a cut-off point for subject selection.

For all psychiatric patients, information on at least four of the five social competence indices was usually found in the clinical charts. This chart information was the basis for a preselection of psychiatric patients in high and low social competence groups. For medical and surgical patients, usually two or three of the social competence indices were found in the clinical records, and a preselection was made on the basis of the available information.

After the initial preselection, each potential subject was asked to volunteer to participate in the study. Patients were told that their participation was voluntary, that the study was in no way related to their hospital treatment programs, and that their records would be confidential and anonymous. Seven psychiatric patients and five medical/surgical patients declined to participate during the initial contact. Patients who volunteered were given appointments for the first testing session.

The following measures were completed by all subjects:

1. Biographical Information form
2. Shipley-Hartford Intelligence survey
3. Trait Lists for self and ideal ratings
4. Questionnaires for self and ideal ratings
5. Q-Sorts for self and ideal ratings
6. Repression-Sensitization scale
7. Social Desirability scale
8. Role Orientation scale
9. Maudsley Personality Inventory
10. Vocabulary test

Subjects first completed the Biographical Information form and then the Shipley-Hartford Intelligence survey. The three self-concept measures were then presented in rotated sequence (ABC, BCA, ACB, BAC, etc.). The other measures were then presented in random order. All subjects completed at least items 1 through 5, above, during the first testing session. Most subjects did not complete the battery in

one session, and appointments were made for additional sessions at the termination of the current testing.

Psychiatric patients were tested singly or in groups of two or three in an office or small room. Medical and surgical patients were tested singly or in groups of 2 in their hospital rooms. Total testing time per subject varied from 2 hours to 7 hours, and the number of testing sessions varied from 1 to 4.

A total of 109 patients began the test battery. Of these, 29 subjects were lost from the study during the course of testing: six because they were discharged from the hospital before testing was completed, seven because they decided not to complete the battery, 11 because they refused to complete the Q-Sorts and five because they completed the Q-Sorts incorrectly. Of the seven who decided not to complete the battery, five made the decision when presented the Q-Sort. The other two declined to continue testing when presented with the Shipley-Hartford. The list and classification of subjects lost from the study is shown in Appendix H.

Analysis of Data

Descriptive Statistics

Means and Standard Deviations were calculated for all four groups on the variables age, length of hospitalization, social competence rating, and the five variables contributing to the social competence rating. These descriptive statistics were also found for the number of discrepancies between biographical information found in clinical records and that

information given by subjects on the Biographical Information form. T-tests for differences between means were then calculated for appropriate groups on each of the above variables.

Analyses of Variance

A total of 15 2x2 ANOVAS were computed for type of patient and social competence on the following variables:

1. Number of changes on the Trait List
2. Number of changes on Questionnaire
3. Magnitude of changes on Questionnaire
4. Zero extreme shifts on Questionnaire
5. Maximum extreme shifts on Questionnaire
6. Number of changes on Q-Sort
7. Social Desirability score
8. Role Orientation score
9. Repression-Sensitization score
10. Extraversion score
11. Neuroticism score
12. Questionnaire, scaled real scores
13. Questionnaire, scaled ideal scores
14. Trait List, scaled real scores
15. Trait List, scaled ideal scores

Two 2x2x2 ANOVAS were computed for type of patient and social competence on the variables:

1. Real and ideal Questionnaire extreme responses
2. Combined Vocabulary error scores

The Tukey multiple range test (Snedecor & Cochran, 1956) was used to clarify significant interactions in ANOVAS.

Correlations

A correlation matrix was obtained for all 80 subjects on all of the variables in the study. Partial correlations were then computed among the variables social competence, repression-sensitization and social desirability and their relationships to the self-image disparity measures.

CHAPTER III

RESULTS

Group means for social competence and the five social competence indices are shown in Table 5. For overall social competence, t-tests indicated no significant differences between psychiatric and nonpsychiatric subjects in each competence level.

With respect to competence levels, t-tests were not significant for the variables of intelligence and marital status. High competence psychiatric subjects had significantly higher education ratings ($p < .01$) and occupation ratings ($p < .05$) than high competence nonpsychiatric subjects. Low competence psychiatric patients had higher occupation ratings than their nonpsychiatric counterparts ($p < .02$), while low competence nonpsychiatric subjects had better employment histories than psychiatric low competence subjects ($p < .01$).

For psychiatric patients, it was possible to compare two sources of information on the biographical data from which social competence was rated: clinical charts and self-reports on the biographical information form. There was no conflicting information found for high competence subjects. Nine of the 20 low competence subjects had at least one conflicting item of information between the two sources ($\bar{X} = .70$). The inaccurate information was found to be all on the

Table 5

Group Means for Social Competence, Shipley-Hartford I.Q., Five Social Competence Indices--I.Q., Education, Occupation, Employment History and Marital Status--and Conflict in Information on Two Sources of Biographical Data

Group	Soc. Comp.	S-H I.Q.	I.Q.	Ed.	Occup.	Empl. Hx.	Mar. Stat.	Conflict of Info.
High Competence Psychiatric	1.73	126.35	1.85	1.90	1.85	1.85	1.20	0.00
High Competence Nonpsychiatric	1.71	122.20	1.95	1.45	1.50	1.95	1.70	
Low Competence Psychiatric	.63	101.55	1.10	1.00	.45	.40	.25	.70
Low Competence Nonpsychiatric	.65	101.70	.80	.90	.10	.90	.55	
t-tests:								
High Competence	n.s.	n.s.	n.s.	p<.01	p<.05	n.s.	n.s.	p<.01
Low Competence	n.s.	n.s.	n.s.	n.s.	p<.02	p<.01	n.s.	n.s.

Biographical Information form and was in the predicted direction of self-enhancement.

Social Competence and Self-Image Disparity

Summation of Discrepancy Scores

Group means for the three measures of self-image disparity are presented in Table 6. Results of the 2x2 Analyses of Variance (type of patient x social competence) for the three disparity measures are shown in Tables 7, 8 and 9.

For the Questionnaire, as shown in Table 7, there was a highly significant social competence effect in the predicted direction. The types of patient effect and interaction were also significant. The Tukey multiple range test indicated that the significant interaction term reflected differences between high competence psychiatric and nonpsychiatric subjects ($Q = 29.29$, $p < .01$).

Findings for the Trait List, shown in Table 8, indicate a significant social competence effect in the predicted direction. The type of patient effect was also significant. The interaction term was not significant. As can be seen in Table 6, mean scores for all groups were higher on the Questionnaire than on the Trait List.

On the Q-Sort, as shown in Table 9, the only significant effect was for social competence levels, with high competence subjects again showing greater self-image disparity.

In summary, it was found that high social competence subjects showed greater self-image disparity than low social competence groups on all three measures of self-image disparity.

Table 6

Group Means and Standard Deviations
for Simple Discrepancy Scores on
Questionnaire, Trait List and Q-Sort

Group	N	Questionnaire		Trait List		Q-Sort	
		M.	S.D.	M.	S.D.	M.	S.D.
High Competence Psychiatric	20	22.90	3.08	12.85	4.30	38.70	3.36
High Competence Nonpsychiatric	20	22.00	3.57	8.60	5.76	36.30	5.47
Low Competence Psychiatric	20	16.00	4.93	8.40	5.96	29.20	13.03
Low Competence Nonpsychiatric	20	9.45	5.10	7.05	5.58	32.25	9.09

Table 7

Analysis of Variance of Number of Changes
on Questionnaire

Source	SS	df	MS	F
Treatments	2328.638	3		
Type of Patient (P)	277.513	1	277.513	15.297***
Social Competence (C)	1891.513	1	1891.5120	104.265***
P x C	159.613	1	159.613	8.789***
Error	1378.750	76	18.1415	

****p < .0005

***p < .005

Table 8
 Analysis of Variance of Number of Changes
 on Trait List

Source	SS	df	MS	F
Treatments	378.850	3		
Type of Patient (P)	156.800	1	156.800	5.303*
Social Competence (C)	180.000	1	180.000	6.088*
P x C	42.050	1	42.050	1.422
Error	2247.100	76	29.567	

* $p < .05$

Table 9
 Analysis of Variance of Number of
 Changes on Q-Sort

Source	SS	df	MS	F
Treatments	1068.638	3		
Type of Patient (P)	2.113	1	2.113	0.029
Social Competence (C)	918.013	1	918.013	12.509****
P x C	14.851	1	14.851	2.204
Error	5577.350	76	73.386	

****p < .001

On the Trait List and the Questionnaire it was found that psychiatric subjects demonstrated greater self-image disparity than nonpsychiatric subjects. The type of patient effect on the Questionnaire was found to be due to large differences between low competence groups. All groups had higher mean scores on the Questionnaire than on the Trait List.

Directional Scoring of Self and Ideal Ratings

Mean scores for real and ideal ratings on the Trait List and Questionnaire are shown in Table 10. Results of the analyses of variance for real scores are shown in Tables 11 and 12, and results of analyses of variance for ideal scores are shown in Tables 13 and 14.

Analysis of Trait List self ratings, shown in Table 11, indicated a significant social competence effect and a significant type of patient effect. Both high social competence subjects and psychiatric subjects had poorer self ratings than low competence and nonpsychiatric subjects.

For the Questionnaire, as can be seen in Table 12, both type of patient and social competence effects were significant. Paralleling the Trait List findings, high competence subjects and psychiatric subjects had the poorer self-ratings.

As shown in Table 13, analysis of Trait List ideal scores revealed no significant effects. Analysis of the Questionnaire ideal scores, as shown in Table 14, yielded only a significant social competence effect, with low

Table 10

Group Means and Standard Deviations for Real and Ideal Self Directional Scores on Trait List and Questionnaire

Group	N	Trait List		M.	S.D.	Ideal		M.	S.D.	Questionnaire	
		Real	Ideal			Real	Ideal			Real	S.D.
High Competence Psychiatric	20	16.35	4.52	23.30	1.81	96.20	12.73	70.00	12.05		
High Competence Nonpsychiatric	20	20.40	5.02	27.05	4.47	37.55	12.12	63.60	14.02		
Low Competence Psychiatric	20	20.20	5.38	26.50	3.43	92.35	21.82	65.20	20.25		
Low Competence Nonpsychiatric	20	22.30	4.03	26.30	4.74	74.00	14.98	58.00	11.47		

Note: Trait List-high score = positive image
Questionnaire-low score = positive image

Table 11
 Analysis of Variance of
 Trait List Real Self Scores

Source	SS	df	MS	F
Treatments	373.438	3		
Type of Patient (P)	189.113	1	189.113	7.842***
Social Competence (C)	165.313	1	165.313	6.855***
P x C	19.013	1	19.013	0.788
Error	1832.750	76	24.115	

*** $p < .01$

Table 12

Analysis of Variance of
Questionnaire Real Self Scores

Source	SS	df	MS	F
Treatments	5629.250	3		
Type of Patient (P)	3645.000	1	3645.000	14.441*****
Social Competence (C)	1513.800	1	1513.800	5.998**
P x C	470.450	1	470.450	1.864
Error	1982.700	76	250.404	

***** $p < .0005$

** $p < .025$

Table 13

Analysis of Variance of
Trait List Ideal Self Scores

Source	SS	df	MS	F
Treatments	4853.750	3		
Type of Patient (P)	10.513	1	10.513	0.733
Social Competence (C)	32.513	1	32.513	2.266
P x C	5.513	1	5.513	0.384
Error	1090.350	76	14.347	

Table 14
 Analysis of Variance of
 Questionnaire Ideal Self Scores

Source	SS	df	MS	F
Treatments	1522.550	3		
Type of Patient (P)	312.050	1	312.050	1.413
Social Competence (C)	1080.450	1	1080.450	4.892*
P x C	130.050	1	130.050	0.589
Error	16786.200	76	220.871	

* $p < .05$

competence subjects having higher aspiration levels.

Magnitude of Change and Extreme Responding on the Questionnaire

In addition to scoring the number of changes between real and ideal Questionnaires, the magnitude (0-5) of changes was summed. The number of extreme responses for both real and ideal Questionnaires was also scored and summed. Mean scores on these variables are reported in Table 15, and results of analyses of variance for these variables are shown in Tables 16 and 17.

Results of analysis of variance for magnitude of change are shown in Table 16. Only the type of patient effect was significant, with psychiatric subjects showing a larger magnitude of change than nonpsychiatric subjects.

For the extreme measure, as can be seen in Table 17, there was found a highly significant social competence effect in the predicted direction. There was a type of patient x social competence interaction, which was found to be due to differences between the low competence groups (Tukey Q = 33.54, $p < .05$).

To clarify the relationship between magnitude of change and extreme responses, analyses of variance were performed for the number of zero extreme changes and the number of Maximum Extreme changes on the Questionnaire. Zero extreme shifts were scores of either 1 or 6 on both real and ideal questionnaires. Maximum extreme shifts were the number of items showing the maximum five point disparity between real and ideal Questionnaires. Group means for zero and maximum

Table 15
Group Means and Standard Deviations for Questionnaire
Magnitude of Change, Extreme Responses, Zero
Extreme Changes and Maximum Extreme
Changes

Group	N	Magnitude		Extreme Responses				Zero Chgs.		Maximum Chgs.	
		M.	S.D.	M.	S.D.	Real	Ideal	M.	S.D.	M.	S.D.
High Competence Psychiatric	20	42.95	9.78	5.50	1.13	9.00	4.97	2.65	2.76	.90	2.36
High Competence Nonpsychiatric	20	34.60	15.27	4.74	3.81	8.10	4.69	2.85	2.85	.50	1.19
Low Competence Psychiatric	20	41.80	22.32	16.40	6.24	20.05	7.83	10.25	5.82	3.25	3.73
Low Competence Nonpsychiatric	20	26.05	15.86	20.60	5.91	23.35	6.18	10.65	4.75	2.45	2.06

Table 16

Analysis of Variance of Magnitude of Change
Between Real and Ideal Questionnaires

Source	SS	df	MS	F
Treatments	3648.300	3		
Type of Patient (P)	2904.050	1	2904.050	10.772***
Social Competence (C)	470.450	1	470.450	1.745
P x C	273.800	1	273.800	1.016
Error	20489.900	76	269.604	

*** $p < .005$

Table 17

Analysis of Variance of Number of
Extreme Responses on Questionnaire

Source	SS	df	MS	F
Between Subjects				
Type of Patient (P)	85.556	1	85.556	1.640
Social Competence (C)	7035.756	1	7035.756	134.835*****
P x C	209.306	1	209.306	4.011*
Error	3965.000	76	52.181	
Within Subjects				
Type of Question- naire (Q)	438.906	1	438.906	34.391*****
Q x P	2.756	1	2.756	0.216
Q x C	.506	1	.506	0.040
Q x P x C	1.406	1	1.406	0.110
Error	969.925	76	12.762	

***** $p < .0005$

* $p < .05$

extreme shifts are presented in Table 15. Results of analyses of these variables are shown in Tables 18 and 19.

Results for zero extreme shifts, as shown in Table 18, indicated significant social competence effects, with low competence subjects having the greater number of zero extreme shifts. The type of patient and interaction were also significant. The multiple range test indicated the interaction was due to differences between low competence subjects (Tukey $Q = 28.62$, $p < .01$).

Findings for the maximum extreme shifts, shown in Table 19, indicated only a significant social competence effect, with low competence subjects making more maximum extreme shifts.

Vocabulary Errors

It was predicted that a significant number of low competence subjects would fail to understand a greater number of words on the Q-Sort than key words on the other two self-image measures. To test this prediction, an 88 item vocabulary test consisting of the 44 Q-Sort words and the 44 nonoverlapping key items on the Trait List and Questionnaire was used. Vocabulary error scores were scored for Q-Sort words, other words and total. Group means for vocabulary errors are shown in Table 20. A $2 \times 2 \times 2$ analysis of variance was performed for the vocabulary errors. Results of this analysis are shown in Table 21.

Results of the analysis of vocabulary errors, shown in Table 21, indicated a significant social competence effect

Table 18

Analysis of Variance of Number of
Zero Extreme Shifts on Questionnaire

Source	SS	df	MS	F
Treatments	2699.800	3		
Type of Patient (P)	217.800	1	217.800	12.070****
Social Competence (C)	2289.800	1	2289.800	126.896*****
P x C	192.200	1	192.200	10.651***
Error	1371.400	76	18.045	

***p < .005

****p < .001

Table 19

Analysis of Variance of Number of
Maximum Extreme Shifts on Questionnaire

Source	SS	df	MS	F
Treatments	10.045	3		
Type of Patient (P)	7.200	1	7.200	1.146
Social Competence (C)	92.450	1	92.450	14.715*****
P x C	0.800	1	0.800	0.127
Error	477.500	76	6.283	

***** $p < .0005$

Table 20

Group Means and Standard Deviations
for Vocabulary Errors

Group	N.	Q-Sort Words		Trait List and Questionnaire Words	
		M.	S.D.	M.	S.D.
High Competence Psychiatric	20	4.65	3.31	1.85	1.90
High Competence Nonpsychiatric	20	6.25	3.45	2.35	2.13
Low Competence Psychiatric	20	12.95	9.19	6.55	2.26
Low Competence Nonpsychiatric	20	16.15	8.63	6.90	4.53

Table 21

Analysis of Variance of Combined Vocabulary Errors

Source	SS	df	MS	F
Between Subjects				
Type of Patient (P)	82.656	1	82.656	1.474
Social Competence (C)	1870.056	1	1870.056	33.301*****
P x C	6.006	1	6.006	0.107
Error	4262.775	76	56.089	
Within Subjects				
Type of Vocabulary (V)	1237.656	1	1237.656	204.271*****
V x P	41.006	1	41.006	6.768**
V x C	195.806	1	195.806	32.317*****
V x P x C	8.556	1	8.556	1.412
Error	460.475	76	6.059	

*****p < .0005

**p < .025

and the predicted type of vocabulary effect. Two interaction terms, vocabulary x social competence and vocabulary x type of patient, were also significant. Multiple range tests indicated that the type of vocabulary x social competence interaction was due to the fact that, while all subjects made more errors on Q-Sort items, low competence subjects made more errors than high competence subjects on all vocabulary items ($p < .01$), and low competence subjects made proportionately more errors on the Q-Sort items ($p < .01$). The type of vocabulary x type of patient interaction was found to reflect the nonpsychiatric subjects' proportionately higher number of errors on the Q-Sort items ($p < .01$).

In summary, the following relationships were found between social competence and self-image disparity.

1. Social competence was related to self-image disparity on all three of the measures used, with high competence subjects showing greater disparity.
2. Social competence was related to real-self images on both measures of this variable, with high competence subjects having poorer self images.
3. Social competence was related to ideal-self ratings on one of the two measures of this variable, with high competence subjects showing poorer ideal-self images.
4. There was no difference between competence groups on the magnitude of change between real and ideal questionnaires.

5. Social competence was related to extreme responses zero extreme shifts and maximum extreme shifts on the Questionnaire, with low social competence subjects giving more of these extreme responses than high competence subjects.
6. All subjects were unable to define a greater number of words on the Q-Sort than on the other two measures of self-image disparity, while low competence subjects and medical subjects made a significantly greater number of errors than high competence and psychiatric subjects.

Self-Image Disparity and Adjustment

Defining adjustment and maladjustment a priori on the basis of type of hospitalization, psychiatrically hospitalized subjects were defined as maladjusted and medical or surgical subjects were defined as adjusted. Results of analyses using this classification of subject groups were reported above for the self-image disparity measures. A summary of these findings concerning the relationship of self-image disparity to adjustment follows.

1. Self-image disparity was positively related to adjustment on two of the three measures (Trait List and Questionnaire) with psychiatric subjects having a greater disparity than nonpsychiatric subjects. For the Questionnaire, it was found that only high social competence psychiatric and nonpsychiatric subjects were significantly different in self-image disparity.

2. Real self ratings were significantly related to adjustment on both measures of this variable, with psychiatric subjects having poorer self ratings than nonpsychiatric subjects.
3. No differences were found between psychiatric and nonpsychiatric subjects on either of the two ideal-self ratings.
4. Psychiatric subjects showed significant greater magnitude of discrepancy between real and ideal ratings than nonpsychiatric subjects.
5. Nonpsychiatric subjects showed a greater number of zero extreme shifts than psychiatric subjects on the Questionnaire.

Social Competence and the Other Variables

Social Desirability

To test the prediction that social competence would be negatively related to social desirability, a 2x2 analysis of variance was performed for the Marlowe-Crowne Social Desirability scale. Group means for social desirability are shown in Table 22. Results of the analysis, shown in Table 23, indicated the predicted social competence effect. The type of patient term was also significant, with nonpsychiatric subjects having the greater social desirability scores.

Repression-Sensitization

To test the prediction that social competence would be related to repression-sensitization, an analysis of variance was performed for the Byrne Repression-Sensitization scale. Group means for repression-sensitization are shown in Table 22. Results of the analysis, as can be seen in Table 24, found

Table 22

Group Means and Standard Deviations of Other Variables:
 Social Desirability, Repression-Sensitization,
 Role Orientation, Neuroticism and Extraversion

Group	N	Social Desirability		Repression-Sensitization		Role Orientation		Neuroticism		Extraversion	
		M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.
High Competence Psychiatric	20	8.65	5.22	89.95	19.95	10.38	.52	35.10	9.20	21.55	8.17
High Competence Nonpsychiatric	20	14.50	7.18	63.55	19.28	5.96	.30	19.80	13.39	28.60	9.63
Low Competence Psychiatric	20	17.95	5.88	67.75	27.01	5.64	.28	24.15	14.69	23.65	9.63
Low Competence Nonpsychiatric	20	22.05	5.23	52.45	20.48	3.20	.16	18.30	11.09	32.90	7.27

Note: Role Orientation scores based on Role 1/Roles 1,2,3.

Table 23
 Analysis of Variance of
 Marlowe-Crowne Social Desirability Scale

Source	SS	df	MS	F
Treatments	1790.938	3		
Type of Patient (P)	446.513	1	446.513	12.876****
Social Competence (C)	1336.612	1	1336.612	38.545*****
P x C	7.813	1	7.813	0.225
Error	2635.450	76	34.677	

****p < .0005

****p < .001

Table 24
Analysis of Variance of
Repression-Sensitization Scale

Source	SS	df	MS	F
Treatments	14864.738	3		
Type of Patient (P)	8715.313	1	8715.313	18.153*****
Social Competence (C)	5527.813	1	5527.813	11.514*****
P x C	621.613	1	621.613	1.295
Error	36488.650	76	480.114	

***** $p < .0005$

*** $p < .001$

the predicted social competence effect. The type of patient effect was also significant, with psychiatric subjects having the higher (sensitization) scores.

Role Orientation

Phillips' Role Orientation scale was used as another measure of defensive style. The Role Orientation scale comprises three role orientations. It was predicted that social competence would be positively related to the Role 1 or "turning against the self" orientation. The scale is scored by dividing the number of role 1 responses by the total role 1, 2 and 3 responses, yielding a per cent role 1 responses score. Group means on per cent role 1 responses are shown in Table 22. Results of the ANOVA, shown in Table 25, indicated the predicted social competence effect. The type of patient effect was also significant, with psychiatric patients having the greater percentage of role 1 orientations.

Another test of role orientation was used for psychiatric subjects: the classification of psychiatric symptoms into role orientations. Symptoms were classified by the Zigler and Phillips role orientations, and the scoring was the same as for the Role Orientation scale, yielding a per cent role 1 symptom type. Group means for symptom orientations are shown in Table 26, where it can be seen that t-tests revealed significant differences in the expected directions.

Neuroticism-Extraversion

The Maudsley Personality Inventory was used to evaluate the relationship between social competence and neuroticism. The inventory yields two scores, one for neuroticism and one for extraversion-intraversion. Group means for the two scales are presented in Table 22.

Table 25

Analysis of Variance of Role Orientation
Scale: Percent Role 1 Responses

Source	SS	df	MS	F
Treatments	1.340	3		
Type of Patient (P)	58.825	1	58.825	19.889*****
Social Competence (C)	70.313	1	70.313	23.773*****
P x C	490.050	1	490.050	1.657
Error	2.248	76	.0295	

***** $p < .0005$

Table 26

Group Means and t-values for Psychiatric
Patients' Symptom Role Orientations (N = 40)

Role Orientation	Low Competence	High Competence	t
Role 1-Turning Against Self	.85	3.50	-9.598*
Role 2-Turning Against Others	2.00	.65	5.180
Role 3-Turning Away from Others	2.00	.60	4.795*
Role 1/Roles 1,2,3	.15	.77	-12.782*

* $p < .01$

Findings for the Neuroticism scale, shown in Table 27, indicated a highly significant type of patient effect ($p < .0005$) and a smaller social competence effect ($p < .05$). The interaction term was not significant. For the Extraversion-Introversion scale, as shown in Table 28, the only significant effect was for type of patient.

Correlations

Social Competence

Correlations among the five indices of social competence and overall Social Competence rating are presented in Table 29, where it can be seen that all of the correlations are significant and positive.

Table 30 shows the correlates of Social Competence. It can be seen that all of the dependent variables correlated significantly with social competence with the exception of Questionnaire magnitude of change and the Neuroticism and Extraversion scales. Variables positively correlated with social competence were Trait List; Questionnaire and Q-Sort number of discrepancies; Repression-Sensitization; Role Orientation; and Symptom Role Orientation.

Correlating negatively with social competence were Questionnaire extreme responses, zero and maximum shifts; Social Desirability; Vocabulary errors and number of conflicting reports in biographical data.

Social Competence, Social Desirability and Repression-Sensitization

Of major interest for the present study were the

Table 27
 Analysis of Variance of
 Maudsley Neuroticism Scale

Source	SS	df	MS	F
Treatments	3458.138	3		
Type of Patient (P)	2236.613	1	2236.613	14.841*****
Social Competence (C)	775.013	1	775.013	5.143*
P x C	446.513	1	446.513	2.963
Error	11453.750	76	150.707	

*****p < .005

*p < .05

Table 28
 Analysis of Variance of
 Maudsley Extraversion Scale

Source	SS	df	MS	F
Treatments	1557.450	3		
Type of Patient (P)	1328.450	1	1328.450	17.431*****
Social Competence (C)	204.800	1	204.800	2.687
P x C	24.200	1	24.200	0.318
Error	5792.100	76	76.213	

***** $p < .0005$

Table 29

Correlations of Social Competence Variables
with Each Other and with Social Competence Rating

	I.Q.	Educ.	Occup.	Empl. Hx.	M.S.	Soc. Comp.
I.Q.	-----					
Education	.5238*	-----				
Occupation	.6136*	.7598*	-----			
Employment History	.4517*	.4745*	.5795*	-----		
Marital Status	.3659*	.2542+	.4823*	.5835*	-----	
Social Competence	.7419*	.7330*	.8752*	.8067*	.7271*	-----

+ $p < .05$

* $p < .001$

Table 30
Correlates of Social Competence

Variable	N	r With Social Competence	p <
Conflicting Information	40	-.4075	.01
Trait List	80	.2777	.05
Q-Sort	80	.3995	.001
Questionnaire			
Number	80	.6738	.001
Magnitude	80	.1448	n.s.
Real Extreme	80	-.7330	.001
Ideal Extreme	80	-.7067	.001
Zero Max. Shift	80	-.7130	.001
Maximum Shift	80	-.3875	.001
Repression-Sens.	80	.3051	.01
Social Desirability	80	-.5193	.001
Scale Role Orientation			
Per cent Role 1	80	.4178	.001
Symptom Role Orientation			
Per cent Role 1	40	.9072	.001
Vocabulary			
Q-Sort	80	-.5932	.001
T.L. & Quest.	80	-.5525	.001
Neuroticism	80	.1852	n.s.
Extraversion	80	-.1900	n.s.

correlations among the variables social competence, social desirability and repression-sensitization. These are shown in Table 31, where it can be seen that the correlations were significant and in the predicted directions. Social competence was positively related to repression-sensitization and negatively related to social desirability. Repression-sensitization and social desirability were negatively correlated, with repressors manifesting high social desirability response sets.

Of further interest to the investigation were the relationships between social competence, social desirability and repression-sensitization and each of the three self-image disparity measures. These correlations are shown in Table 32 where it can be seen that all three variables correlate significantly with each of the self-image disparity measures in the expected directions.

Other Important Correlations

The three self-image disparity measures were significantly intercorrelated. The Trait List correlated .4168 with the Questionnaire and .4036 with the Q-Sort. The Questionnaire correlated .3710 with the Q-Sort. Each of the above correlations is significant at the .001 level.

The Repression-Sensitization scale and the Role Orientation scale correlated .8433 ($p < .001$). Repressors showed "turning against others" or "turning away from others" orientations and sensitizers showed "turning against the self" orientations.

Table 31

Correlations of Social Competence, Social
Desirability and Repression-Sensitization

Variable	S.C.	S.D.	R-S
Social Competence	-----		
Social Desirability	-.5193**	-----	
Repression-Sensitization	.3051*	-.6501**	----

* $p < .01$

** $p < .001$

Table 32

Correlations of Social Competence, Repression-Sensitization and Social Desirability with Trait List, Questionnaire and Q-Sort Measures of Self-Image Disparity

	Trait List	Question- naire	Q-Sort
Social Competence	.2777*	.6738***	.3995***
Repression- Sensitization	.6010***	.5046***	.2665**
Social Desirability	-.5891***	-.6033***	-.3345**

* $p < .05$

** $p < .01$

*** $p < .001$

Partial Correlations

Results of ANOVAS and correlations revealed that social competence, social desirability and repression-sensitization were significantly related to each other and to the three self-image disparity measures. In order to clarify the relationships among these variables, partial correlations were obtained. Results of partial correlations for social competence, social desirability and repression-sensitization are shown in Table 33.

Partial correlations indicated that when the effects of social desirability were removed, social competence and repression-sensitization were no longer significantly related. Social competence and social desirability remained significantly related when repression-sensitization effects were removed, and repression-sensitization and social desirability remained significantly related when social competence effects were removed.

The relative effects of social competence, social desirability and repression-sensitization were then obtained for each of the three self-image disparity measures by partial correlations. These findings are shown in Tables 34, 35 and 36.

For the Questionnaire, as shown in Table 34, it was found that eliminating social desirability effects removed the significance of the repression-sensitization - questionnaire relationship. The social competence - questionnaire and social desirability - questionnaire relationships remained significant.

For the Trait List, as shown in Table 35, removal of

Table 33

Correlations and Partial Correlations for Social Competence,
Repression-Sensitization and Social Desirability

Variables	r	Variables	partial r
Social Competence + Repression-Sensitization	.3051*	S.C. + R-S - Social Desirability	-.0498
Social Competence + Social Desirability	-.5193**	SC + SD - Repression-Sensitization	-.4436**
Repression-Sensitization + Social Desirability	-.6501**	R-S + SD - Social Competence	-.6042**

* $p < .01$

** $p < .001$

Table 34

Correlations and Partial Correlations for Social Competence,
 Repression-Sensitization and Social Desirability
 on the Questionnaire

Variables	r	Variables	partial r
Social Competence + Questionnaire	.6738***	SC + Quest. - Social Desirability	.5290***
Questionnaire + Social Desirability	-.6033***	Quest. + SD - Social Competence	-.4013***
Questionnaire + Repression-Sensitization	.5046***	Quest. + R-S - Social Competence	.4250***
		Quest. + SC - Repression- Sensitization	.6324***
		Quest. + R-S - Social Desirability	.1855
		Quest. + SD - Repression- Sensitization	-.4197***

***p < .001

Table 35

Correlations and Partial Correlations for Social Competence,
 Repression-Sensitization and Social Desirability
 on the Trait List

Variables	r	Variables	partial r
Trait List + Social Competence	.2777*		
Trait List + Social Desirability	-.5891***	TL + SC - Social Desirability	-.0408
		TL + SD - Social Competence	-.5419***
Trait List + Repression-Sensitization	.6010***	TL + R-S - Social Competence	.5643***
		TL + SC - Repression- Sensitization	.1240
		TL + R-S - Social Desirability	.4059***
		TL + SD - Repression- Sensitization	.3267**

*p < .05

**p < .01

***p < .001

Table 36

Correlations and Partial Correlations for Social Competence,
 Repression-Sensitization and Social Desirability
 on the Q-Sort

Variables	r	Variables	partial r
Q-Sort + Social Competence	.3995****	Q-Sort + SC - Social Desirability	.2803**
Q-Sort + Social Desirability	.3345***	Q-Sort + SD - Social Competence	-.1622
Q-Sort + Repression-Sensitization	.2665*	Q-Sort + R-S - Social Competence	.1657
		Q-Sort + SC - Repression- Sensitization	.3466***
		Q-Sort + R-S - Social Desirability	.0685
		Q-Sort + SD - Repression- Sensitization	-.2202*

*p<.05

**p<.025

***p<.01

****p<.001

social desirability effects eliminated the significance between social competence and Trait List. Removal of repression-sensitization effects also eliminated the relationship between social competence and Trait List. The relationships between Trait List and social desirability and between Trait List and repression-sensitization remained significant after partial correlations.

For the Q-Sort, shown in Table 36, the significant relationship with social competence remained after effects of social desirability and repression-sensitization were partialled out. The relationship between Q-Sort and social desirability remained significant after repression-sensitization was removed, but was not significant when social competence was partialled out. The relationship between Q-Sort and repression-sensitization was not significant after social competence and social desirability were removed.

Summary of Hypotheses and Findings

Social Competence and Self-Image Disparity

1. The prediction that high social competence subjects would show more self-image disparity than low social competence subjects on both the Trait List and Questionnaire was supported. The ANOVA findings were significant at the .05 level for the Trait List and at the .0005 level for the Questionnaire.
2. The prediction that no differences would be found between high and low social competence groups on self-image disparity as measured by the Q-Sort was not supported. ANOVA

results for the Q-Sort were similar to those for the Trait List and Questionnaire, with high social competence subjects showing more disparity than low social competence subjects at the .001 significance level.

3. The prediction that low social competence subjects would make more extreme responses on the Questionnaire than high competence subjects was supported, with F-test findings significant at the .0005 level. Low competence subjects were also found to make more Zero Extreme shifts ($p < .0005$) and Maximum Extreme shifts ($p < .0005$) on the Questionnaire.

4. The prediction that subjects would make more errors on the Q-Sort items in the Vocabulary test than on items from the other measures was supported. All subjects missed more Q-Sort items ($p < .0005$). It was also found that low competence subjects missed more items than high competence subjects ($p < .0005$), and nonpsychiatric subjects made more errors than psychiatric subjects ($p < .025$).

Other Hypotheses and Findings

1. The prediction that high competence subjects would tend to be sensitizers and low competence subjects would tend to be repressors on the Repression-Sensitization scale was supported, with ANOVA results significant at the .001 level.

2. The prediction that low competence subjects would manifest more social desirability response set than high competence subjects on the Social Desirability scale was supported by ANOVA findings significant at the .0005 level.

3. The prediction that repressors would score higher than sensitizers on social desirability response set was supported, with the correlation significant at the .001 level.

4. The prediction that high competence subjects would manifest a "turning against the self" orientation on the Role Orientation scale, while low competence subjects would manifest either "turning against others" or "turning away from others" orientations was supported. Results of ANOVA of per cent Role 1 (turning against the self) responses on this measure were significant at the .0005 level in the predicted direction.

5. The prediction that psychiatric subjects' Symptom Role Orientation would be "turning against the self" for high competence subjects and "turning against others" or "turning away from others" for low competence subjects was supported, with t-test results significant beyond the .01 level.

6. The prediction that sensitizers would show a "turning against the self" orientation on the Role Orientation scale, while repressors would manifest "turning against others" or "turning away from others" orientations was supported. The correlation between the Repression-Sensitization scale and the Role Orientation scale was significant at the .001 level in the predicted direction.

7. The prediction that psychiatric subjects would score higher than nonpsychiatric subjects on the Neuroticism scale was supported, with F-test results significant at the .0005

level. The prediction that no differences between social competence groups would be found for the Neuroticism scale was not supported, as high competence subjects were found to score higher than low competence subjects on this scale ($p < .05$).

CHAPTER IV

DISCUSSION

The major hypotheses concerning social competence and self-image disparity were supported in this investigation. High social competence individuals were found to manifest a greater self-image disparity than low competence individuals, and the social competence variable was found to be the most consistent determinant of self-image disparity.

Predictions concerning the other variables in the investigation were also supported, and some of the contradictory findings concerning self-image disparity were clarified in the present study. An integration and discussion of the primary findings follows.

Social Competence

The five biographical variables used to rate social competence--intelligence, education, occupation, employment history and marital status--were found to be highly related to each other and to overall social competence rating, thus supporting the assumption that each of these variables is an important index of social maturity or social competence.

All three measures of self-image disparity were found to be significantly related to social competence. The finding that both the Questionnaire and the Trait List were positively related to social competence was predicted, and adds

further support to the developmental position advanced by Zigler and his colleagues (Achenbach & Zigler, 1963; Katz & Zigler, 1967). Contrary to expectation and to Feder's (1968) finding, the Q-Sort was also positively related to self-image disparity.

It has been suggested that Feder's negative findings may have been due to erroneous placement of subjects into social competence categories as a result of her method of ascertaining biographical data. The findings of the present investigation appear to support that view. It was found that almost half of the low competence subjects provided incorrect or misleading information on Feder's biographical information form. One plausible interpretation of the discrepant findings between this and Feder's study would then be that Feder's subjects were rated for social competence with unreliable biographical information, leading to misplacement of some subjects in social competence categories.

Other findings of this study appear to support the above view. The finding that low competence subjects manifested a significant social desirability response set, as predicted, indicates that these subjects would attempt to present themselves in a positive, if inaccurate, manner. The finding that partial correlation revealed a large decrease in the relationship between social competence and Q-Sort when social desirability was removed further supports this interpretation.

It is likely that the subject selection criteria and procedures were also important in the differential findings of the present and the previous study. In the present

investigation, emphasis was placed on selection of subjects clearly representing high or low social competence categories; accuracy of biographical data for rating social competence was checked when possible; and potential subjects scoring in the mid-range on social competence and potential subjects expressing reluctance to participate were excluded from the study. The highly significant findings for this investigation may partially reflect this attention to subject selection and procedure.

The significant finding that low competence subjects made more extreme responses on the Questionnaire is consistent with earlier findings (Achenbach & Zigler, 1963; Katz & Zigler, 1967), and supports the developmental hypothesis that low competence individuals manifest less cognitive differentiation than more mature subjects. Further support for this view was found in the proportions of zero extreme and maximum extreme discrepancy scores. Low social competence subjects made more of both kinds of extreme shifts, indicating their tendency to respond "very good" or "very bad," and avoiding finer differentiations. The finding that subjects showed more self-image disparity on the Questionnaire than on the Trait List is in keeping with the findings of Achenbach and Zigler, and further supports the developmental hypothesis that cognitive differentiation is an important component of development.

It seems clear that the tendency for low competence subjects to respond in extremes confounded the magnitude of discrepancy variable. Low competence subjects made many zero and five-point changes between real and ideal ratings,

while high competence subjects made more two or three point changes, leading to similar overall magnitude of change scores.

The finding that high competence subjects had poorer self-images than low competence subjects is consistent with earlier findings supporting the developmental position. For ideal ratings, there were no differences between competence groups on the Trait List, while low competence subjects showed higher aspiration levels on the Questionnaire. The finding of higher aspirations for low competence is contrary to all theoretical and empirical predictions, and may be due to the tendency of low competence subjects to respond in extremes. It is possible that either there were no differences between competence groups in aspiration levels, as indicated by the Trait List findings, or that the extreme responding of low competence subjects masked higher aspiration levels of high competence subjects on the Questionnaire.

Katz and Zigler (1968) found that higher developmental children had both lower self concepts and higher ideals than lower developmental children. The range of ideal extreme responses for children (11.8 - 13.3) was much smaller than the range of ideal extreme responses for adults in the present study (8.10 - 23.35), and thus the Katz and Zigler findings were less subject to confounding by the extreme response variable.

Three Measures of Self-Image Disparity

Findings for the three tests of self-image disparity studied in the present investigation revealed important

differences in the measures, although all three provided significant results.

Findings for the Trait List indicated that it is influenced by social desirability, that it does not permit the influence of cognitive differentiation to be manifest, and that it is related to the psychopathology-oriented Repression-Sensitization scale of defensiveness.

The Q-Sort was found to be incomprehensible for a significant number of subjects. This measure appears to have eliminated some social desirability response set at the expense of eliminating some understanding of the task as well. Findings on the Vocabulary test as well as subject reactions support this view. A total of 16 subjects were lost in this study either because they refused to complete the Q-Sort or because they completed it incorrectly. Some subjects who completed the Q-Sort expressed negative feelings about it. For example, one subject commented "I think this is a bad test...it forces you to misrepresent yourself" (subject # 211). Another subject (# 414) commented, "This form is meaningless. I was boxed in after the first eight items."

The disparate findings for the Q-Sort between this study and the Feder investigation might be due to the fact that subjects were permitted to refuse the Q-Sort task in this investigation. Feder reports no loss of subjects due to refusal of this task. In the present investigation, all subjects understood that their participation was voluntary and that they would not be penalized for refusal. Subjects were also tested singly or in groups of two or three, which might

have facilitated their candid reactions. In view of the findings of this study, it seems possible that some of Feder's subjects may have wished to reject the Q-Sort but felt constrained from doing so. It is impossible to judge the exact influence such subject reactions might have had on the Feder experimental findings.

Feder found a significant ($p < .05$) relationship between the Q-Sort and repression-sensitization. In the present study, the correlation between Q-Sort and repression-sensitization was also significant at the .05 level. When the effects of social desirability were partialled out in the present investigation, the relationship between Q-Sort and repression-sensitization was not significant. There thus appears to be a great deal of overlap between the Social Desirability and Repression-Sensitization scales.

The Questionnaire was significantly related to social competence and adjustment; it provided measures of cognitive differentiation in the extreme responses, zero extreme responses and maximum extreme responses, and it proved to be highly related to social competence, social desirability and repression-sensitization. Partial correlation revealed that the relationship between Questionnaire and repression-sensitization measures was not significant when effects of social desirability were removed, again indicating the overlap between repression-sensitization and social desirability.

Consistent with the Achenbach and Zigler (1963) and Katz and Zigler (1967) findings, the Questionnaire was found

to reflect the cognitive differentiation factor in self-image disparity. The finding that the Questionnaire produced greater disparity scores than the Trait List is also consistent with the previous developmental findings.

Adjustment

Defining adjustment a priori on the basis of type of hospitalization, self-image disparity was related to adjustment in the manner suggested by Rogers. Psychiatric subjects had greater self-image disparity than nonpsychiatric subjects. Also consistent with the Rogerian position, psychiatric subjects had poorer self concepts than nonpsychiatric subjects. It appears from these findings that within social competence levels there is variability in self-image disparity that reflects the adjustment-maladjustment continuum.

Findings for patient groups on the other variables indicate that nonpsychiatric subjects showed more social desirability response set or need for approval, tend to be repressors, and tend to have "turning against others" or "turning away from others" role orientations.

The fact that psychiatric subjects were sensitizers as opposed to repressors is consistent with Feder's (1968) findings. It is also consistent with findings for the MMPI scales from which the Repression-Sensitization scale is derived. The sensitization scale is based upon the Depression, Psychasthenia and Welsh Anxiety scales of the MMPI. Persons with high scores on these scales have been described as neurotic, self-doubting and insecure (Van DeRiet & Wolking,

1964). It appears logical that neurotic, insecure and self-doubting individuals (sensitizers) would be more likely to seek psychiatric hospitalization than would repressors. The repression scale is composed of items from the MMPI Lie, Correction and Hysteria scales. Persons who score high on these scales have been described as repressive, defensive and unable to take criticism (Van De Riet & Wolking, 1964).

Social Competence and Adjustment

The similar findings for social competence and adjustment status in this study pose the question of the relationship between these two variables. It was suggested in Chapter I that social competence might be the major determinant of self-image disparity, while the adjustment-maladjustment factor might operate within competence levels. The findings for self-image disparity in this investigation appear to support that interpretation. Findings on the other variables--social desirability, repression-sensitization, role orientation and neuroticism--also support this view. For each of these variables, the subject group with the most extreme scores was the high competence psychiatric group. In other words, all of the predicted effects were most pronounced for the group that showed both high competence and maladjustment, possibly indicating that the maladjustment factor interacted with the social competence effects. It would then be expected that a maladjusted individual at a given social competence level would manifest the pathological behavior concomitant with his competence level. This is the developmental position

which has been supported by Zigler and his colleagues.

The fact that psychiatric subjects showed a greater "self deprivation and turning against the self" role orientation is consistent with the findings for repression-sensitization. Individuals who manifest anxiety, lack of self confidence and poor self concepts (sensitizers) are those who have been found to manifest the "turning against the self" role orientation.

Defensiveness

The prediction that repression-sensitization would be related to social competence was supported. Other findings indicated that the Repression-Sensitization scale was most significantly related to social desirability response set and psychopathology. While the analysis of variance and correlational analyses indicated a relationship between repression-sensitization and social competence, partial correlation indicated that the relationship was not significant when social desirability was removed.

Crowne and Marlowe (1964) have found that social desirability response set reflects a need for approval, a dependence upon external factors for determining behavior. Viewed in this light, both repression-sensitization and social desirability appear to be concomitants of maturational level, with the maturing individual becoming increasingly independent and introspective or sensitizing:

Role orientation, the other measure of defensiveness, was clearly related to social competence. High social

competence subjects showed the predicted "turning against the self" role orientation, consistent with the earlier developmental findings (Zigler & Phillips, 1960). Confirming the utility of the Role Orientation scale, high social competence psychiatric subjects were found to manifest more symptom role 1 orientations.

Social Competence, Social Desirability and Repression-Sensitization

It appears from the present findings that both social desirability and repression-sensitization are related to social competence. The relationship between social competence and social desirability was in the predicted direction, as was the relationship between social competence and repression-sensitization. The findings indicated a good deal of overlap between social desirability and repression sensitization. These results were consistent with the developmental position that most behavior is related to maturational level. There has been some controversy about whether defensive style (repression-sensitization) primarily reflects social desirability (c.f. Feder, 1967). The present findings seem to indicate that the two variables overlap, possibly because they both reflect an individual's maturational or social competence level. The characteristics of dependency (social desirability) and denial (repression) are both reflections of immaturity. Likewise, the characteristics of independence from a need for approval and self-criticalness found for high social competence subjects appear to indicate their higher developmental level.

CHAPTER V

SUMMARY

The study was designed to investigate the relationship between social competence and self-image disparity. Three measures of self-image disparity were used and were found to be positively related to social competence, consistent with the findings of Zigler and his colleagues (Achenbach & Zigler, 1963; Katz & Zigler, 1967) but contrary to the findings of Feder (1968). It was postulated that the Feder negative findings might have been due to subject selection, procedural and task variables, and evidence was found for these interpretations.

Findings for self-image disparity supported the developmental position that disparity increases with increasing maturation or social competence. It was found that cognitive differentiation was an important concomitant of maturational level as indicated by self-ideal disparity.

It was also found that social desirability, repression-sensitization, role orientation and psychiatric symptomatology were related to social competence in a manner consistent with the developmental interpretation of these indices.

Adjustment was found to be related to self-image disparity in the manner suggested by Rogers and his colleagues (Rogers & Dymond, 1954), and the findings indicated that the

social competence and adjustment factors interacted to produce the greatest self-image disparity for subjects who were both high competence and maladjusted.

It was concluded that social competence, as reflecting maturity level, was the most important determinant of self-image disparity in the present investigation. The relationships between social competence, social desirability, role-orientation and repression-sensitization were consistent with the interpretation that each of these variables reflects an individual's maturational level.

APPENDICES

APPENDIX A
BIOGRAPHICAL INFORMATION FORM

Name _____ Occupation _____
Age _____

Please answer the following questions in the space allotted:

1. a. How many grades did you complete in school?
b. Did you ever go to college or any school after high school?
c. If your answer to (b) is yes, how many years of school did you complete after high school?
2. What sort of work do you do?
3. a. How long have you held your present job? (or last job)
b. Do you do seasonal or part-time work only?
c. List all the jobs you have held in the past 5 years:
d. What is the longest period you have ever been out of work?
4. Make a checkmark () for your answers to the following questions:
 - a. Are you married: yes _____; no _____
 - b. Have you ever been married: yes _____; no _____
 - c. Have you ever been:
Separated: yes _____; no _____
Divorced: yes _____; no _____
Widowed: yes _____; no _____

APPENDIX B

TRAIT LIST

For each of the following traits, quickly circle yes if you would like it to be true and circle no if you would not like it to be true of you.

1. inferior	yes no	16. self-respecting	yes no
2. selfish	yes no	17. shy	yes no
3. tactful	yes no	18. hot-tempered	yes no
4. self-confident	yes no	19. impulsive	yes no
5. moody	yes no	20. unemotional	yes no
6. patient	yes no	21. lazy	yes no
7. restless	yes no	22. friendly	yes no
8. easy-going	yes no	23. suspicious	yes no
9. good-natured	yes no	24. fair-minded	yes no
10. lonely	yes no	25. responsible	yes no
11. careful	yes no	26. out-going	yes no
12. adventurous	yes no	27. cheerful	yes no
13. stubborn	yes no	28. self-conscious	yes no
14. calm	yes no	29. guilty	yes no
15. open-minded	yes no	30. irritable	yes no

APPENDIX C
QUESTIONNAIRE

For each of the following statements, check the answer which indicates how true the statement is.

1. I often let myself go when I am angry.
☐ This is very true of me
☐ This is quite true of me
☐ This is slightly true of me
☐ This is slightly untrue of me
☐ This quite untrue of me
☐ This is very untrue of me
2. I can do certain things much better than the average person.*
3. I like to take life easy.
4. I am willing to help other people who are in trouble.
5. I feel out the opinions of others before making a decision.
6. I enjoy myself at parties or other social gatherings.
7. I have a sense of responsibility about my duties. I do what is expected of me.
8. I enjoy a good hot argument.
9. My likes and dislikes change frequently.
10. I have a good sense of humor.
11. I am ready to stand up for my rights.
12. I prefer easy tasks to difficult ones.
13. I go my own way regardless of the opinion of other people.

*Nos. 2-30 in the Real-Self Questionnaire are followed by the options shown in No. 1 above.

APPENDIX C (continued)

14. I am shy with women.
15. I get bored rather easily.
16. I depend a lot upon the judgement of my friends.
17. When I meet a stranger I think he is a better man than I am.
18. I don't mind having jokes played on me.
19. I make enemies without realizing it.
20. I feel uncomfortable if I have to be my myself any length of time.
21. I often think about how I look and what impression I am making upon other people.
22. I can work at a difficult task for a long time without getting tired of it.
23. I bear grudges.
24. I often imitate or agree with someone whom I consider a superior person.
25. I do favours for friends whenever I can.
26. I sometimes act on the spur of the moment, without stopping to think.
27. I have great faith in my own ideas.
28. I am able to keep working day in and day out without getting tired or bored.
29. I often feel anoyed with myself.
30. I make friends easily.*

*Nos. 1-30 in the Ideal-Self Questionnaire are followed by the options:

- ___ I would like this to be very true of me
- ___ I would like this to be quite true of me
- ___ I would like this to be slightly true of me
- ___ I would like this to be quite untrue of me
- ___ I would like this to be very untrue of me

APPENDIX D

Q-SORT

The Way I Am

1	2	3	4	5	6	7	8	9	10	11
Best Describes Me								Most Poorly Describes Me		

- | | | |
|-----------------|-------------------|-----------------|
| 1. ardent✓ | 16. formal | 31. poetic |
| 2. bashful | 17. hesitant | 32. profound |
| 3. busy | 18. indifferent | 33. romantic |
| 4. candid | 19. inquisitive | 34. sensible |
| 5. casual | 20. intuitive | 35. sentimental |
| 6. cautious | 21. leisurely | 36. serious |
| 7. changeable | 22. materialistic | 37. shy |
| 8. complex | 23. moderate | 38. skeptical |
| 9. conservative | 24. naive | 39. solemn |
| 10. daring | 25. nonchalant | 40. spontaneous |
| 11. deliberate | 26. noncommittal | 41. studious |
| 12. detached | 27. passive | 42. talkative |
| 13. eager✓ | 28. penetrating | 43. timid |
| 14. emotional | 29. permissive | 44. wary |
| 15. excitable | 30. philosophical | |

APPENDIX E

ROLE ORIENTATION QUESTIONNAIRE

Key Scale 1. Turning Against the Self Attitude Scale

- | | |
|----|--|
| T | 1. Most of the time I feel blue. |
| T. | 2. I have periods of such great restlessness that I cannot sit long in a chair. |
| F | 3. I can concentrate as long as other people can. |
| T | 4. I have met problems so full of possibilities that I have been unable to make up my mind about them. |
| F | 5. I enjoy life. |
| F | 6. I seem to have enough confidence in myself. |
| T | 7. Life is a strain for me much of the time. |
| F | 8. I seldom feel blue. |
| F | 9. I am happy most of the time. |
| T | 10. I sometimes am afraid that others might think me stupid or ignorant. |
| T | 11. I feel I daydream too much. |
| T | 12. I often feel as if nothing is real. |
| T | 13. I frequently find myself worrying about something. |
| F | 14. I think the future is going to be a pretty exciting time for me. |
| T | 15. I don't seem to care what happens to me. |
| T | 16. I have strange and peculiar thoughts. |
| T | 17. I feel anxiety about something or someone almost all the time. |
| F | 18. I feel that I can usually make up my mind with great ease. |

APPENDIX E (continued)

Key Scale 1. Turning Against the Self Attitude Scale

- T 19. I dread the thought of the future
- F 20. My daily life is full of things that keep me interested.
- F 21. I am always careful about my manner of dress.
- T 22. I sometimes feel that I am about to go to pieces.
- T 23. Even when I am with people I feel lonely much of the time.
- T 24. The future seems hopeless to me.
- T 25. It makes me feel like a failure when I hear of the success of someone I know well.

Scale 2. Turning Against Others Attitude Scale

- F 1. Whenever I've been punished there was a good reason.
- T 2. I sometimes wonder what hidden reason another person has for doing something nice for me.
- T 3. I like to be where there is something doing all the time.
- T 4. Sometimes I've felt I had to do something whether I wanted to or not.
- T 5. I try to correct people who express an ignorant belief.
- T 6. It's rare for me to feel weak all over.
- F 7. I would never think of letting someone else be punished for my wrongdoings.
- T 8. I enjoy promoting a new project.
- T 9. There are many fools that I strongly dislike.
- T 10. I usually work things out for myself rather than get someone to show me how.
- F 11. I dislike eating in new and strange restaurants.
- T 12. I am seldom bothered by thoughts about sex.

APPENDIX E (continued)

Key Scale 2. Turning Against Others Attitude Scale

- F 13. Every little effort seems to wear me out.
- F 14. I enjoy almost all foods.
- F 15. I have had periods of days, weeks or months where I couldn't "get going."
- T 16. It's safer to trust nobody.
- T 17. If I could get into a movie without paying and be sure I was not seen I would probably do it.
- T 18. I enjoy making fun of people who do things I regard as stupid.
- T 19. At times I feel like picking a fist fight with someone.

Key Scale 3. Avoidance of Others Attitude Scale

- T 1. I eat about as usual even when I am emotionally upset.
- T 2. I wish I were not so shy.
- T 3. The members of my family and my close relatives get along quite well.
- T 4. The past was a happy time for me.
- F 5. At times I have insisted on having things my own way.
- T 6. I am happiest when alone.
- T 7. I am always courteous, even to people who are disagreeable.
- T 8. I rarely get cross and grouchy.
- T 9. Socially, I am a poor mixer.
- F 10. I sometimes try to get even rather than forgive and forget.
- F 11. In school I found it was easy to talk before the class.
- T 12. I have never been in love with anyone.

APPENDIX E (continued)

Key Scale 3. Avoidance of Others Attitude Scale

- T 13. It is more important for a child to be bright than to be well-adjusted socially.
- T 14. I find that eating candy or chewing gum helps when I get upset.
- F 15. I like to flirt.
- T 16. I am more interested in planning a project than carrying it out.

APPENDIX F

ROLE ORIENTATION SYMPTOM LIST

1. Self-deprivation and turning against the self:

suicidal attempt	headaches
suicidal ideas	self-depreciatory
euphoria	depressed
doesn't eat	fears own hostile impulses
bodily complaints	mood swings
tense	insomnia

2. Self-indulgence and turning against others:

maniacal outbursts	irresponsible behavior
perversions (except homosexuality)	assaultive
drinking	threatens assault
rape	emotional outbursts
robbery	homosexuality

3. Avoidance of others:

suspiciousness
perplexed
bizarre ideas
hallucinations
sexual preoccupation
apathetic
withdrawn

APPENDIX G
VOCABULARY TEST

In the test below, the first word in each line is printed in capital letters. Opposite it are four other words. Draw a line under the one word that means the same thing, or most nearly the same thing, as the first word. If you don't know, guess. Be sure to underline one word in each line that means the same as the first word.

SAMPLE

LARGE	red	<u>big</u>	silent	wet
1. ARDENT	typical	cautious	smart	affectionate
2. BASHFUL	capable	shy	loud	blessed
3. BUSY	active	serious	indulgent	poetic
4. CANDID	small	meek	frank	warm
5. CASUAL	pure	relaxed	character	robust
6. CAUTIOUS	careful	caustic	honest	friendly
7. COMPLEX	dependable	wasteful	intricate	competitive
8. CHANGEABLE	variable	distinct	proper	trustworthy
9. CONSERVATIVE	calm	modern	moderate	outspoken
10. DARING	different	moody	fright	bold
11. DELIBERATE	deformed	dangerous	happy	purposeful
12. DETACHED	distinct	aloof	alarmed	sad

13. EAGER	anxious	serious	happy	enthusiastic
14. EMOTIONAL	feeling	growing	willing	immature
15. EXCITABLE	upset	evasive	placid	amiable
16. FORMAL	favorable	forgetful	enviable	conventional
17. HESITANT	gay	hopeful	powerful	indecisive
18. INDIFFERENT	inept	grateful	unconcerned	forlorn
19. INQUISITIVE	creative	curious	impartial	impatient
20. INTUITIVE	perceptive	gracious	indirect	forgiving
21. LEISURELY	inconsiderate	hasty	unhurried	arduous
22. MATERIALISTIC	wise	spiritual	worldly	realistic
23. MODERATE	reasonable	fretful	modest	extreme
24. NAIVE	simple	obedient	mature	nagging
25. NONCHALANT	warm	obtuse	casual	belligerent
26. NONCOMMITTAL	boast	conforming	thinking	uninvolved
27. PASSIVE	active	confident	unresisting	participating
28. PENETRATING	discerning	blunt	popular	discriminating
29. PERMISSIVE	passive	tolerant	harsh	habitual
30. PHILOSOPHICAL	fun	thrifty	theoretical	phlegmatic
31. POETIC	lyrical	phobic	poised	relaxed
32. PROFOUND	profane	nagging	deep	domineering

33. ROMANTIC	artistic	brash	reluctant	tender
34. SENSITIVE	reformed	truthful	abrasive	responsive
35. SENTIMENTAL	touchy	emotional	sensible	sensual
36. SERIOUS	awkward	interest	solemn	frivolous
37. SHY	unhappy	timid	popular	intellectual
38. SKEPTICAL	forlorn	indirect	questioning	confident
39. SOLEMN	grave	obedient	patient	particular
40. SPONTANEOUS	hard	natural	peaceful	moderate
41. STUDIOUS	helpful	effable	diligent	strenuous
42. TALKATIVE	jabber	obese	wise	impartial
43. TIMID	simple	fearful	bother	sporting
44. WARY	eager	disappoint	cautious	elaborate
45. INFERIOR	large	less	drab	better
46. SELFISH	self-reproach	self-centered	self-effacing	self-conscious
47. TACTFUL	spontaneous	wary	considerate	competent
48. CONFIDENCE	agreement	conviction	evident	disorderly
49. MOODY	moriant	temperamental	timid	repressed
50. PATIENT	foolish	reticent	calm	boring
51. RESTLESS	outgoing	uneasy	sensitive	euphoric

52. EASYGOING	solemn	bold	relaxed	poetic
53. GOOD NATURED	pristine	deserving	pleasant	intruding
54. LONELY	casual	solitary	loose	rally
55. CAREFUL	cautious	sly	tepid	ensue
56. ADVENTUROUS	deadly	daring	deposed	wasted
57. STUBBORN	unhappy	hopeless	unyielding	convex
58. CALM	sound	vain	still	deep
59. OPEN MINDED	smart	reasonable	devout	excited
60. RESPECT	reduce	esteem	strew	defy
61. SHY	timid	unhappy	warm	peculiar
62. HOT TEMPERED	tilted	cautious	fiery	pointed
63. IMPULSIVE	courteous	silent	demented	spontaneous
64. UNEMOTIONAL	incite	unfeeling	first	outcast
65. LAZY	rigid	help	rash	lax
66. FRIENDLY	sound	outgoing	lentil	sparse
67. SUSPICIOUS	vain	revoke	untrusting	involatile
68. FAIR MINDED	harsh	reasonable	recall	allow
69. RESPONSIBLE	deserve	large	fame	dependable
70. OUTGOING	welcome	friendly	stolen	divide

71. CHEERFUL	swift	open	happy	red
72. SELF CONSCIOUS	caustic	unformed	pretend	uncomfortable
73. GUILTY	signify	blameworthy	young	ignorant
74. IRRITABLE	grouchy	waste	belittle	lament
75. OPINION	ensue	judgment	incite	vein
76. DECISION	timid	charm	choice	rally
77. HUMOR	funny	stem	course	mitigate
78. DIFFICULT	help	hard	turn	out
79. BORED	delight	plain	timidity	uninterested
80. JUDGMENT	abuse	opinion	devout	tease
81. UNCOMFORTABLE	level	impetuous	unpleasant	undone
82. IMPRESSION	idea	talk	loose	turn
83. GRUDGE	resent	complain	desire	sound
84. IMITATE	tumble	fix	yield	copy
85. SUPERIOR	defy	swift	better	wet
86. FAVOR	pin	gift	merit	fan
87. FAITH	Bible	book	bitter	belief
88. ANNOY	drive	bother	fight	talk

APPENDIX H
SUBJECTS LOST DURING TESTING

Group	Total n	Reason for Loss	n
High Competence Psychiatric	4	Incomplete Battery (Stopped at Q-Sort)	1
		Refused Q-Sort	3
High Competence Nonpsychiatric	3	Discharged	1
		Refused Q-Sort	1
		Incorrect Q-Sort	1
Low Competence Psychiatric	8	Incomplete Battery (Stopped at Shipley- Hartford)	1
		Incomplete Battery (Stopped at Q-Sort)	1
		Refused Q-Sort	5
		Incorrect Q-Sort	1
Low Competence Nonpsychiatric	14	Discharged	5
		Incomplete Battery (Stopped at Shipley- Hartford)	1
		Incomplete Battery (Stopped at Q-Sort)	3
		Refused Q-Sort	2
		Incorrect Q-Sort	3

APPENDIX I

RAW DATA

Codes

Subject Numbers:

- 100 = Psychiatric, Low Competence
- 200 = Psychiatric, High Competence
- 300 = Nonpsychiatric, Low Competence
- 400 = Nonpsychiatric, High Competence

Hospitals: 1 = Montrose V.A. Hospital

2 = Worcester State Hospital

3 = Hall-Brooke Hospital

4 = East Orange V.A. Hospital

5 = St. Raphael's Hospital

Race: 1 = Caucasian

2 = Negro

Role Orientation & Symptom Role Orientation:

1 = Turning Against the Self

2 = Turning Against Others

3 = Turning Away from Others

APPENDIX I continued

Subject Number	Hosp.	Race	Age	IQ	Social Competence Indices				
					IQ	Ed.	Occ.	E.Hx.	M.S.
101	1	2	36	102	1	1	0	0	0
102	1	1	49	110	1	1	1	0	1
103	1	1	49	115	2	1	0	0	0
104	1	1	22	99	1	1	1	1	1
105	1	2	44	82	0	1	0	1	1
106	1	1	55	103	1	1	1	0	0
107	1	1	24	94	1	1	0	0	0
108	1	1	51	99	1	1	0	1	0
109	1	1	31	104	1	1	0	1	1
110	1	1	54	94	1	1	1	0	1
111	1	1	20	99	1	1	1	0	0
112	2	1	43	81	0	1	0	0	0
113	2	1	20	98	1	1	1	0	0
114	2	1	29	94	1	1	1	1	0
115	2	1	28	119	2	1	0	1	0
116	2	1	19	104	1	1	0	0	0
117	1	2	32	128	2	1	1	0	0
118	1	1	38	93	1	1	1	1	0
119	1	1	23	111	2	1	0	0	0
120	1	1	25	103	1	1	0	1	0

APPENDIX I continued

Subject Number	Hosp.	Race	Age	IQ	Social Competence Indices				
					IQ	Ed.	Occ.	E.Hx.	M.S.
201	1	1	50	104	1	1	1	2	2
202	1	1	21	111	2	2	2	1	0
203	1	1	45	130	2	2	2	2	2
204	1	2	29	110	1	2	2	2	1
205	1	1	49	127	2	2	2	2	1
206	1	2	43	142	2	2	2	2	1
207	3	1	24	133	2	2	2	1	0
208	3	1	32	143	2	2	2	2	1
209	1	1	55	142	2	2	2	2	2
210	1	1	47	119	2	2	2	1	2
211	1	1	42	138	2	2	2	2	2
212	1	1	24	132	2	2	1	2	0
213	1	1	47	138	2	2	2	2	1
214	3	1	35	129	2	2	2	2	2
215	3	1	55	137	2	2	2	2	2
216	1	1	42	105	1	2	2	2	1
217	1	1	47	117	2	1	1	2	2
218	1	1	22	123	2	2	2	2	0
219	1	2	42	120	2	2	2	2	0
220	3	1	44	127	2	2	2	2	2

APPENDIX I continued

Subject Number	Hosp.	Race	Age	IQ	Social Competence Indices				
					IQ	Ed.	Occ.	E.Hx.	M.S.
301	5	1	50	106	1	0	0	2	1
302	4	1	25	122	2	1	0	0	0
303	4	1	19	119	2	1	0	0	0
304	5	1	42	94	1	1	0	1	0
305	5	2	30	98	1	1	0	1	1
306	5	1	20	104	1	1	0	1	0
307	5	2	40	92	1	1	0	1	1
308	5	1	19	107	1	1	0	1	0
309	5	1	44	105	1	1	0	1	1
310	5	1	58	110	1	1	1	0	1
311	5	1	50	109	1	1	0	1	1
312	5	1	41	109	1	1	1	1	0
313	5	2	51	93	1	1	0	0	1
314	5	1	42	100	1	0	0	1	1
315	4	1	45	85	0	1	0	1	0
316	5	1	56	89	0	1	0	2	0
317	5	1	38	97	1	1	0	1	1
318	5	1	37	91	1	1	0	1	1
319	5	1	46	104	1	1	0	1	1
320	4	1	19	100	1	1	0	1	0

APPENDIX I continued

Subject Number	Hosp.	Race	Age	IQ	Social Competence Indices				
					IQ	Ed.	Occ.	E.Hx.	M.S.
401	5	1	46	120	2	2	1	2	0
402	5	1	49	135	2	1	1	2	2
403	5	1	46	130	2	1	1	2	2
404	5	1	58	131	2	2	2	2	2
405	5	1	26	132	2	2	2	1	2
406	5	2	45	112	2	1	0	2	2
407	4	1	41	119	2	1	2	2	2
408	5	1	19	113	2	1	2	2	0
409	5	1	47	127	2	1	1	2	2
410	5	1	30	128	2	2	2	2	2
411	5	1	52	96	1	1	2	2	2
412	5	1	45	120	2	1	1	2	2
413	5	1	32	115	2	1	1	2	2
414	5	1	48	117	2	2	2	2	2
415	5	1	30	118	2	2	2	2	2
416	5	1	47	124	2	2	2	2	2
417	5	2	20	124	2	2	1	2	0
418	5	1	43	126	2	1	2	2	2
419	5	1	36	129	2	2	2	2	2
420	5	1	44	128	2	1	1	2	2

APPENDIX I continued

Subject Number	S.C.	Lies	Discrepancies			Questionnaire		
			T.L.	Quest.	Q-Sort	Mag. Chg.	Real Extr.	Ideal Extr.
101	.4	1	4	12	29	28	22	21
102	.8	1	19	20	38	58	17	19
103	.6	2	0	9	10	15	16	20
104	.8	0	16	23	41	88	19	30
105	.6	1	7	7	0	28	25	30
106	.6	0	3	11	16	20	16	29
107	.4	0	0	15	35	20	5	1
108	.6	1	16	19	27	45	7	8
109	.8	2	15	20	34	42	14	12
110	.8	1	6	11	23	33	20	21
111	.6	2	8	12	41	14	9	15
112	.2	0	5	14	0	32	25	21
113	.6	0	9	16	40	61	26	26
114	.8	0	7	20	36	50	18	21
115	.8	0	20	26	29	94	16	26
116	.4	0	6	14	31	27	13	23
117	.8	3	5	16	37	57	19	30
118	.8	0	2	15	41	27	20	10
119	.6	0	13	21	38	40	6	18
120	.6	0	9	19	38	57	19	20

APPENDIX I continued

Subject Number	S.C.	Lies	Discrepancies			Questionnaire		
			T.L.	Quest.	Q-Sort	Mag. Chg.	Real Extr.	Ideal Extr.
201	1.4	0	8	23	39	37	5	8
202	1.4	0	22	24	39	42	2	6
203	2.0	0	15	23	38	61	13	13
204	1.6	0	12	21	36	37	10	12
205	1.8	0	9	26	30	34	5	9
206	1.8	0	17	23	43			
207	1.4	0	12	20	40	44	14	10
208	1.8	0	18	24	40	55	4	3
209	2.0	0	16	25	40	48	1	2
210	1.8	0	8	25	35	36	0	7
211	2.0	0	16	25	42	45	1	1
212	1.4	0	13	27	40	54	1	12
213	1.8	0	15	26	42	54	1	9
214	2.0	0	11	15	44	33	17	20
215	2.0	0	17	27	38	54	4	10
216	1.6	0	8	20	38	46	11	20
217	1.6	0	6	21	41	36	8	8
218	1.6	0	12	22	37	39	1	8
219	1.6	0	15	23	39	43	4	10
220	2.0	0	7	18	33	19	2	4

APPENDIX I continued

Subject Number	S.C.	Lies	Discrepancies			Questionnaire		
			T.L.	Quest.	Q-Sort	Mag. Chg.	Real Extr.	Ideal Extr.
301	.8	---	12	12	39	40	19	27
302	.6	--	7	16	33	41	13	24
303	.6	--	14	18	36	52	14	30
304	.6	--	1	11	0	47	27	28
305	.8	--	0	3	35	3	11	10
306	.6	--	12	9	33	29	25	30
307	.8	--	2	13	29	30	25	13
308	.6	--	6	10	37	24	23	29
309	.8	---	5	6	22	10	14	11
310	.8	---	1	0	29	0	19	19
311	.8	---	10	4	26	26	39	30
312	.8	---	20	7	43	7	17	24
313	.6	--	3	7	36	21	27	28
314	.6	---	14	0	34	0	21	21
315	.4	---	7	15	32	42	15	21
316	.6	--	4	12	33	28	22	24
317	.8	--	3	16	40	33	12	20
318	.8	--	1	9	31	23	25	25
319	.8	--	13	10	39	39	26	27
320	.6	--	6	11	38	36	28	26

APPENDIX I continued

Subject Number	S.C.	Lies	Discrepancies			Questionnaire		
			T.L.	Quest.	Q-Sort	Mag. Chg.	Real Extr.	Ideal Extr.
401	1.4	--	18	26	40	59	3	2
402	1.6	--	17	16	41	24	8	6
403	1.6	--	6	25	38	0	0	14
404	2.0	--	11	22	34	38	0	0
405	1.8	--	3	26	16	37	1	4
406	1.4	--	0	22	33	40	6	9
407	1.8	--	11	24	33	38	1	10
408	1.4	--	20	26	43	75	11	15
409	1.6	--	8	19	38	27	4	5
410	2.0	--	15	25	38	39	1	8
411	1.6	--	3	16	37	23	2	4
412	1.6	--	8	24	35	35	7	10
413	1.6	--	4	19	40	17	8	9
414	2.0	--	2	23	39	47	11	16
415	2.0	--	6	20	36	38	11	12
416	2.0	--	1	23	38	30	3	0
417	1.4	--	11	18	39	26	4	6
418	1.8	--	7	26	37	39	2	9
419	2.0	--	11	16	34	35	9	13
420	1.6	--	10	24	37	35	3	10

APPENDIX I continued

Subject Number	Zero Chgs.	Questionnaire		Dir. Ideal	Trait List		S.D.
		Max. Chgs.	Dir. Real		Dir. Real	Dir. Ideal	
101	16	3	96	68	27	26	22
102	7	3	100	80	9	24	5
103	14	0	58	61	30	30	26
104	7	13	123	40	14	27	18
105	23	2	86	60	21	26	16
106	18	1	56	39	28	29	21
107	1	0	114	117	15	15	14
108	3	1	118	77	13	27	11
109	5	2	74	94	20	25	18
110	15	2	91	61	18	26	24
111	9	0	64	55	25	27	23
112	15	1	95	73	21	26	23
113	14	9	106	49	21	26	24
114	10	4	91	61	23	30	25
115	3	11	132	37	10	28	11
116	11	0	73	54	24	30	16
117	14	5	79	51	26	29	14
118	8	1	76	95	22	22	23
119	3	2	98	60	16	29	14
120	9	5	117	72	21	28	11

APPENDIX I continued

Subject Number	Zero Chgs.	Questionnaire		Dir. Ideal	Trait List		S.D.
		Max. Chgs.	Dir. Real		Dir. Real	Dir. Ideal	
201	5	0	91	64	20	27	15
202	0	0	103	69	7	29	12
203	4	4	115	96	14	30	9
204	7	0	75	54	17	29	11
205	3	0	93	65	22	30	10
206	2	0	91	80	13	30	5
207	5	10	88	70	16	28	9
208	1	0	121	74	10	28	2
209	1	0	103	70	12	28	4
210	0	0	96	69	23	29	4
211	0	0	97	76	19	27	15
212	0	1	104	76	17	29	4
213	0	0	102	69	15	29	8
214	9	0	68	43	15	27	12
215	1	0	102	55	14	29	5
216	7	2	96	61	23	29	16
217	4	1	87	91	20	22	9
218	0	0	109	77	17	29	3
219	2	0	102	67	11	27	9
220	2	2	81	76	22	30	21

APPENDIX I continued

Subject Number	Zero Chgs.	Questionnaire		Dir. Ideal	Trait List		S.D.
		Max. Chgs.	Dir. Real		Dir. Real	Dir. Ideal	
301	15	5	91	59	16	30	22
302	11	2	99	63	23	29	9
303	12	2	83	45	17	29	18
304	19	7	89	53	27	26	31
305	10	0	81	81	26	26	31
306	21	4	65	60	19	26	16
307	14	1	47	67	28	29	26
308	20	3	64	57	19	24	25
309	11	0	75	75	24	30	17
310	19	0	65	65	28	29	25
311	26	3	66	60	20	30	20
312	17	0	65	60	27	9	24
313	22	3	74	56	23	26	20
314	21	0	56	56	17	29	16
315	11	4	84	71	21	26	21
316	17	4	87	53	24	24	25
317	9	1	97	70	20	21	25
318	20	1	47	36	28	29	25
319	19	4	71	38	19	28	22
320	19	5	74	48	20	26	23

APPENDIX I continued

Subject Number	Zero Chgs.	Questionnaire		Dir. Ideal	Trait List		S.D.
		Max. Chgs.	Dir. Real		Dir. Real	Dir. Ideal	
401	0	0	88	109	16	15	16
402	5	0	81	82	14	30	1
403	0	0	78	57	25	29	14
404	0	0	96	72	20	29	11
405	1	0	96	61	25	28	15
406	5	0	93	47	14	14	12
407	1	0	95	62	19	30	8
408	0	5	118	66	12	27	4
409	1	0	77	74	21	29	23
410	0	1	95	62	14	27	5
411	1	0	89	94	27	30	21
412	4	2	92	68	21	29	23
413	8	0	74	66	25	27	18
414	5	0	58	77	26	28	6
415	9	1	74	54	24	26	20
416	3	0	93	66	29	28	26
417	3	0	86	70	17	28	16
418	1	0	92	66	23	30	24
419	7	1	85	57	16	27	15
420	3	0	91	62	20	30	12

APPENDIX I continued

Subject Number	Role Orientation				R-S	Maudsley	
	Role 1	Role 2	Role 3	% Role 1		Ext.	Neur.
101	0	9	4	0	35	42	4
102	17	14	8	36	117	18	48
103	2	12	7	9	56	28	4
104	23	7	6	64	116	21	32
105	11	14	9	29	57	18	30
106	1	6	4	9	49	24	2
107	13	7	7	48	81	10	20
108	19	9	8	53	102	12	44
109	2	12	7	9	50	29	18
110	3	12	9	13	37	19	4
111	8	11	14	24	48	29	14
112	3	11	14	10	43	30	16
113	2	8	9	11	49	25	19
114	3	14	8	15	47	40	18
115	25	8	8	61	111	10	42
116	6	10	7	17	49	31	27
117	10	9	9	36	77	32	36
118	6	9	9	25	64	6	23
119	13	10	5	46	94	24	43
120	15	10	12	41	75	25	39

APPENDIX I continued

Subject Number	Role 1	Role Orientation			R-S	Maudsley	
		Role 2	Role 3	% Role 1		Ext.	Neur.
201	20	11	5	56	103	27	41
202	23	10	5	61	111	12	46
203	23	11	8	52	119	12	40
204	10	13	3	38	87	30	39
205	20	9	2	65	105	16	40
206	21	10	4	60	108	14	40
207	6	9	5	30	56	36	24
208	22	7	2	71	79	14	46
209	22	4	0	85	91	16	36
210	10	10	8	36	68	12	28
211	15	5	9	52	70	10	20
212	14	13	9	39	83	18	24
213	24	12	3	61	108	20	44
214	11	9	3	48	82	28	36
215	17	10	4	55	101	30	39
216	20	9	5	59	94	19	27
217	10	8	4	45	82	30	42
218	24	10	5	62	104	29	37
219	22	13	4	56	106	28	40
220	1	7	7	7	42	30	13

APPENDIX I continued

Subject Number	Role Orientation				R-S	Maudsley	
	Role 1	Role 2	Role 3	% Role 1		Ext.	Neur.
301	1	8	8	6	30	38	8
302	23	13	9	51	77	12	34
303	8	10	5	31	90	32	42
304	0	8	6	0	49	38	16
305	1	8	7	6	45	37	17
306	8	12	5	32	78	34	42
307	0	7	6	0	43	30	16
308	7	14	6	25	34	36	13
309	2	8	3	15	44	31	18
310	2	12	7	9	56	42	21
311	9	12	6	33	109	22	32
312	0	9	8	0	33	33	6
313	2	7	12	10	46	25	10
314	8	13	1-	26	47	44	19
315	3	13	9	12	44	40	18
316	3	9	9	14	35	32	16
317	6	9	9	25	48	36	16
318	1	5	7	8	41	34	12
319	0	8	8	0	46	24	6
320	4	10	19	17	54	28	4

APPENDIX I continued

Subject Number	Role Orientation				R-S	Maudsley	
	Role 1	Role 2	Role 3	% Role 1		Ext.	Neur.
401	12	8	7	44	91	15	23
402	10	12	5	38	86	14	44
403	4	10	7	19	48	34	4
404	12	5	8	48	58	8	12
405	2	11	7	10	50	45	10
406	11	8	4	48	76	40	44
407	12	9	5	46	87	33	36
408	24	13	5	57	113	33	42
409	4	7	3	29	55	27	22
410	18	9	1	64	76	42	25
411	2	10	9	10	52	23	12
412	6	8	4	37	56	22	12
413	12	8	9	45	71	24	26
414	3	10	4	18	36	26	1
415	1	10	11	5	57	24	8
416	1	7	7	7	53	40	8
417	5	9	6	25	52	31	17
418	2	10	6	11	54	28	27
419	5	8	7	25	60	29	16
420	2	11	8	10	39	34	7

APPENDIX I continued

Subject Number	Vocabulary Errors		Symptom Role Orientation			
	Q-S.	Other	Role 1	Role 2	Role 3	% Role 1
101	12	7	0	2	2	0
102	7	4	1	3	1	20
103	2	3	2	2	2	33
104	21	14	1	1	2	25
105	39	25	1	3	1	0
106	5	1	0	4	0	0
107	7	7	0	0	3	0
108	11	5	0	1	4	0
109	9	1	3	2	3	38
110	14	7	1	2	3	17
111	23	9	1	1	3	20
112	27	18	0	3	1	0
113	17	7	0	3	1	0
114	11	5	1	2	1	25
115	5	1	2	2	2	33
116	8	2	0	3	2	0
117	5	1	2	1	3	33
118	17	9	2	1	2	33
119	13	4	1	2	1	25
120	4	1	0	2	2	0

APPENDIX 1 continued

Subject Number	Vocabulary Errors		Symptom Role Orientation			
	Q-S.	Other	Role 1	Role 2	Role 3	% Role 1
201	8	4	4	0	0	100
202	6	2	3	1	1	60
203	11	1	5	1	1	70
204	6	2	3	1	0	75
205	6	2	3	1	0	75
206	5	3	4	1	1	67
207	4	1	4	1	2	57
208	1	0	5	0	1	83
209	0	0	4	1	2	57
210	4	2	4	0	0	100
211	2	0	2	0	0	100
212	1	0	3	1	0	75
213	6	2	4	1	0	80
214	6	3	3	0	1	75
215	1	0	3	0	2	60
216	3	2	3	2	0	60
217	13	8	3	0	0	100
218	4	2	3	0	1	76
219	6	3	3	1	0	75
220	3	0	4	1	0	80

APPENDIX I continued

Subject Number	Vocabulary Errors		Symptom Role Orientation			
	Q-S.	Other	Role 1	Role 2	Role 3	% Role 1
301	4	0				
302	15	7				
303	16	10				
304	22	8				
305	25	14				
306	37	15				
307	21	7				
308	21	12				
309	4	1				
310	15	3				
311	6	1				
312	5	1				
313	11	5				
314	13	8				
315	27	12				
316	22	10				
317	18	9				
318	20	7				
319	7	2				
320	14	6				

APPENDIX I continued

Subject Number	Vocabulary Errors		Symptom Role Orientation			
	Q-S.	Other	Role 1	Role 2	Role 3	% Role 1
401	8	3				
402	2	0				
403	4	1				
404	1	0				
405	5	2				
406	8	1				
407	4	2				
408	13	7				
409	9	4				
410	4	1				
411	8	6				
412	6	5				
413	4	0				
414	4	1				
415	10	5				
416	12	2				
417	5	1				
418	7	2				
419	1	0				
420	10	4				

APPENDIX I continued

Subject Number	Days in Hosp.	Diagnosis
101	23	Schizophrenic Reaction, Paranoid
102	33	Adult Situational Reaction
103	30	Schizophrenic Reaction, Undifferentiated
104	3	Drug Addiction
105	80	Schizophrenic Reaction, Paranoid
106	17	Schizophrenic Reaction, Paranoid
107	6	Schizophrenic Reaction
108	14	Schizophrenia, Undifferentiated
109	21	Schizophrenic Reaction, Paranoid
110	13	Involitional Paranoid State
111	15	Schizophrenic Reaction, Paranoid
112	30	Chronic Schizophrenic, Affective
113	7	Schizophrenic, Schizo-Affective
114	12	Schizophrenic Reaction, Undifferentiated
115	22	Schizophrenia, Paranoid
116	3	Schizophrenia
117	23	Schizophrenic Reaction, Schizo-Affective
118	18	Schizophreniz, Catatonic
119	7	Schizophrenic Reaction, Schizo-Affective
120	21	Schizophrenic Reaction, Paranoid

APPENDIX I continued

Subject Number	Days in Hosp.	Diagnosis
201	14	Depressive Reaction
202	18	Schizophrenic Reaction, Paranoid
203	4	Depressive Reaction
204	13	Schizophrenic Reaction, Paranoid
205	17	Depressive Reaction
206	40	Schizophrenic Reaction
207	31	Schizophrenia, Paranoid
208	26	Depression
209	9	Paranoia
210	50	Passive-Dependent Personality
211	33	Psychoneurosis, Anxiety Reaction
212	6	Schizophrenia, Undifferentiated
213	14	Obsessive-Compulsive Personality
214	9	Schizophrenia, Schizo-Affective Type and Depression
215	16	Paranoid State
216	26	Depressive Reaction
217	9	Anxiety Reaction
218	7	Schizophrenic Reaction, Schizo-Affective
219	4	Depressive Reaction
220	13	Depressive Neurosis

APPENDIX I continued

Subject Number	Days in Hosp.	Diagnosis
301	10	Broken Leg
302	19	Hepatitis
303	18	Hepatitis
304	7	Renal Stone
305	9	Observation, R/O T.B.
306	8	Tumor on Coccyx
307	58	Broken Leg, Burns
308	11	Renal Colic
309	15	Foot Infection, Diabetes
310	9	Abdominal Pain
311	6	Heart Failure
312	10	Observation, R/O Reiters Syndrome
313	9	Cardiac Arythmia
314	4	Observation, R/O Cancer of Lung
315	17	Ulcers
316	3	Nephritis
317	5	Laryngscopy
318	7	Kidney Stones
319	13	Cardiac Arythmia
320	14	Observation, R/O T.B.

APPENDIX I continued

Subject Number	Days in Hosp.	Diagnosis
401	5	Gastro-Intestinal Disorder
402	7	Observation, possible pulmonary embolism
403	5	Abdominal Pain, possible Bladder Tumor
404	4	Observation, R/O Cancer of Lung
405	9	Cerebritis
406	14	Observation, ? R. Femoral Artery
407	9	Emphesema, acute gastroenteritis
408	7	Hepatitis
409	4	Cardiac Cathode
410	25	Colitis
411	6	Pulmonary Edema
412	21	Heart Failure
413	35	Heart Failure
414	12	Hypertension
415	15	Acute Sinusitis
416	9	Leg Tumor
417	5	Lacerations
418	19	Observation for Heart
419	6	Broken Wrist
420	4	Swollen Lymph Glands

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BIOGRAPHICAL SKETCH

Michaelene M. Plotnik was born in Denver, Colorado, on January 1, 1940. She completed her undergraduate work at the University of Denver, where she was the recipient of a John Evans Scholarship, was president of the Student Body and received her B.A. degree with a major in Psychology and Sociology in 1963. She enrolled at the University of Florida in 1964, and received her M.A. degree with a major in Psychology in 1966. She received Alpha Lambda Delta, U.S.P.H. and N.I.M.H. fellowships while attending the University of Florida. From 1966 to 1969 she resided in New Haven, Connecticut, where she completed two years of internship at the West Haven Veterans Administration Hospital and pursued her work toward the degree of Doctor of Philosophy.

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This dissertation was prepared under the direction of the chairman of the candidate's supervisory committee and has been approved by all members of that committee. It was submitted to the Dean of the College of Arts and Sciences and to the Graduate Council, and was approved as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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